IMPROVING MENTAL HEALTH CARE SERVICES TO MONTANA ELDERS: NEW STRATEGIES AND SOLUTIONS TO ENDURING PROBLEMS

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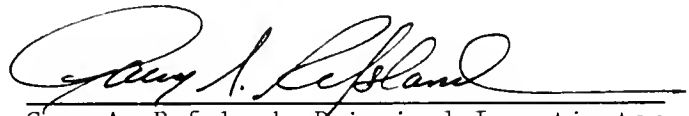

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ABSTRACT

Montana's Department of Family Services (State Unit on Aging), Billings Community Mental Health Center, Montana Area Health Education Center, and the Montana Center of Gerontology developed under the 1987 Coordinated Discretionary Funds Program 2.1.D. a 22-month pilot statewide public education campaign designed to promote better mental health among Montana's elderly, including off-reservation and on-reservation Indian elders: "Improving Mental Health Care Services to Montana Elders: New Strategies and Solutions to Enduring Problems." The overall goal of the project was to initiate a statewide public education campaign intended to convey information to all Montanans regarding symptoms of mental health problems characteristic of the elderly and to provide information that will help them obtain assistance. The project compiled information on the utilization by Montana's older adults of five Community Mental Health Centers and the Indian Health Service for fiscal year 1986-1987, determined the extent of utilization of these services, and identified diagnostic trends and associated frequencies of specific diagnoses among the elderly population. Four quarterly, one-day seminars, that attracted 821 mental health professionals were held in five locations of the State. These seminars were designed to meet the immediate educational needs of licensed mental health professionals and to update their knowledge base in the following areas: normal aging: a baseline for assessing mental health problems of the elderly; psychological strategies applicable to aging; diagnosis and treatment of depression in the elderly; and loss and grief as related to the aging population. Two 28-minute videotapes, "Mental Health Problems of Older Adults" and "Network of Mental Health Services for Older Montanans," were developed and utilized in one-half day seminars that attracted 1,537 participants in 55 counties and in 3 federal Indian reservations. Twelve 30-60-second public service announcements and 12 newspaper articles were prepared and distributed to 14 television stations and 87 newspapers and 17 Title III project newsletters. The topics for the 12 PSAs and newspaper articles included: Leisure and Recreation for Mental Well-Being, Depression, Alcoholism, Loss and Grief, Elder Abuse/Self Neglect, Native American Elderly, Network of Mental Health Services, Suicide, Alzheimer's Disease, Dementia, Substance Abuse, and Intergenerational Relations as a Positive Response to Aging. The 70,000 distributed informational brochures identified problems for which older Montanans seek help at Montana's Community Mental Health Centers, the services commonly provided, and the communities in which mental health centers or satellite offices are located and their respective telephone numbers. Finally, the campaign was concluded with a statewide conference that identified strategies and recommendations for policy and program consideration, which includes the following areas: the funding of Community Mental Health Centers; interagency cooperation in providing mental health care services to older adults; collaborative relationships between the Community Mental Health Centers and other service providers; political and legal changes in Montana's legislative policy; and further development of ways in which mental health care services can be delivered to often rural isolated older adults.

POLICY/PROGRAM IMPLICATIONS

Additional baseline data are needed regarding the health status and social functioning of the Montana elderly, the ability to recognize onset of mental dysfunction, and the provision of social and family support in the community to keep older persons at their highest level of functioning. Institutional, community-based, in-home, and self-help programs can ameliorate the effects of mental illness, as well as prepare persons for the kinds of stress and personal losses that produce symptoms of mental illness.

Since the mental health care system, as it is presently organized, funded, and publicized, has not met all needs of the elderly, further inquiry into the underlying causes is necessary. Treatment modalities and attitudes of Montana's mental health professionals must be further developed and changed, and roles of informed mental health professionals such as psychiatrists, social workers, psychologists, and nurses involved in the mental health treatment of the elderly must be expanded.

There is a growing awareness among mental health professionals that knowledge of the relationship between mental health and aging is crucial. Mental health professionals need specialized education and training in geriatrics and gerontology that should be promoted and supported by adequate public and private funds. Educational institutions in Montana should provide more coursework in gerontology through curriculum development and become more responsive to the needs of the mental health professionals in meeting licensing and certification requirements.

Insufficient funds are available in Montana communities with which to meet the needs of patients no longer cared for in state psychiatric facilities, that is, the funds have not "followed the patients into the community." If funds had followed such terminated patients, then more viable community aftercare services could have been developed. Too often, the responsibility for a patient is interpreted as having ended with a single service provided by a provider, although the client's chronic but changing needs may demand supportive, coordinated, and integrated long-term care.

Standards for defining the essential elements of any effective service system are not in place, nor is an effective mechanism for involving the community in defining its own unique service needs (Kermis, 1986). Moreover, the critical integrated interrelationships between mental health and other human service agencies administered through Titles XIX, XVII, XX, XVI, Administration on Aging, Veterans Administration, and Housing and Urban Development are not yet sufficiently developed.

According to Goldsmith (1984), in order to "prevent, reduce, ameliorate, or cure mental illness, and to provide the most effective treatment possible for those affected with mental disabilities, the following pattern of service is necessary: (1) long-term institutional and community-based services to those with chronic disabilities; (2) intensive, accessible, but often temporary services to the mentally impaired; and (3)

targeted preventive services to those at high risk of mental illness." Each is essential to the further development of a comprehensive system of mental health care. Thus, the further development of an integrated continuum of services with effective authority and linkages among all providers to foster continuity of care is crucial. Further planning must be initiated to increase local participation under overall State policy and adequate funding. A process must be developed to ensure that only those programs that meet real needs, provide quality care, and can demonstrate their effectiveness are supported by public funds. Finally, formula-based funding consistent with patient needs and the integration of medical, home nursing, home health, homemaker, personal care, home delivered meals, shopping assistance, adult day care, housing, congregate housing, respite care, congregate meals, day hospital, legal and financial, information and referral, and mental health services must be effected.

DISSEMINATION AND UTILIZATION

Over the course of the 22-month period involved in the development and implementation of "Improving Mental Health Care Services to Montana Elders: New Strategies and Solutions to Enduring Problems," various initiatives taken were implemented to inform interested parties and the public about the project:

1. On December 11, 1987, John G. Nesbo, Project Director and Center Director of Region III Mental Health Center; Sharon Harris, Psychiatric Nurse and Center Assistant Region III Mental Health Center; and Frank Lane, Executive Director, Region I Mental Health Center, taped a 30-minute television show with Al Nash, Moderator of KXLF's "Face The State." The program was broadcast throughout the State on Sunday, December 13 on KXLF and affiliated stations.

2. On December 14, 1987, Gene Huntington, Montana's Executive Director, State Unit on Aging, notified the States' executives on aging, Federal Region VIII, by letter of the grant award and project objectives. In addition, he notified Montana's 17 Title III project newsletters by letter of the new mental health project. Montana's Area Health Education Center, "Health Information Bulletin," Gallatin County's "Golden Age News," "Pinnacle," and the Rocky Mountain Development Council's "Voice of Experience" all published articles about the project.

3. On December 18, 1987, Nesbo notified 34 community mental health centers located in Federal Region VIII by letter of the grant award and project objectives. Seven of the centers are located in Wyoming, nine in Utah, six in South Dakota, one in North Dakota, and 11 centers in Colorado.

4. On February 8, 1988, a letter was sent by Gary A. Refsland, Principal Investigator, to 738 licensed practicing mental health professionals in the State notifying them of the grant award, which included a summary of project objectives, and requesting that they complete a brief questionnaire concerning topic area suggestions, months for scheduling seminars, occupation, work setting, and attendance of in-state and out-of-state professional conferences or educational presentations.

5. On February 11, Refsland met with the Governor's Coordinator on Aging and members of the Planning Committee, Governor's Conference on Aging and proposed a presentation during the Governor's Conference on Aging. It was decided that a presentation by Nesbo and Refsland would be included in the September Conference.

6. On February 12, Refsland met with two members of the Planning Committee, Montana Gerontology Society, and discussed the annual conference to be held in Lewistown on April 27, 28, and 29. It was determined that Nesbo; Dick Hruska, Director, Region II Mental Health Center; and Refsland would make a presentation on the project to the Conference participants.

7. On February 25, Nesbo presented at a Title IV-A, Area II and Area

VII Agency on Aging, Interorganizational Seminar held in Billings. Eighty-five individuals were in attendance. The Seminar was designed to further the cooperative interorganizational relationships of the "Aging Network" to the Social Security Administration, Veterans Administration, and State Adult Protective Services and Medicaid programs. It was determined that Montana's community mental health centers can be further developed as an important component in the "Aging Network's" array of community-based services for the elderly.

8. On February 28, Refsland discussed the project with three staff, State Unit on Aging and 11 directors, area agencies on aging, during their quarterly meeting in Helena. Roger Ala and Steve Williamson, directors, Area IV and Area VII agencies on aging, respectively, agreed to serve the project by participating in the statewide meeting designed to define the content for the quarterly seminars, 12 public service announcements, two videotapes, and 12 newspaper articles.

9. On February 28, Nesbo asked the Planning Committee, Rocky Mountain Council of Community Mental Health and the National Association for Rural Mental Health Centers to allow him and Refsland to present a workshop during their Conference to be held in Billings on July 31, August 1, 2, and 3.

10. In February/March, the "Golden Star News", Volume 3, Number Four, Missoula, Montana, printed an article on project award and objectives.

11. On March 3, Nesbo presented at a Title IV-A, Areas III, VIII, and X Agency on Aging, Interorganizational Seminar held in Shelby. Forty-two individuals were in attendance. The seminar was designed to further the cooperative interorganizational relationship of the "Aging Network" to the Social Security Administration, Veterans Administration, and State Adult Protective Services and Medicaid programs. It was determined that Montana's community mental health centers can be further developed as an important component in the "Aging Network's" array of community based services for the elderly.

12. On March 7, Refsland presented at a Title IV-A, Areas VI, IX, and XI Agency on Aging, Interorganizational Seminar held in Kalispell. Forty-eight individuals were in attendance.

13. On March 14, Jim Mount, Center Assistant, Eastern Montana Community Mental Health Center, Miles City, presented at a Title IV-A Area I Agency on Aging, Interorganizational Seminar held in Glendive. Forty individuals were in attendance.

14. On April 11, Refsland presented at a Title IV-A, Area IV Agency on Aging, Interorganizational Seminar held in Bozeman. Forty-two individuals were in attendance.

15. On April 25, Refsland notified 738 mental health professionals of the first seminar, "Review of Normal Aging: A Baseline for Assessing Mental Health Problems of the Elderly," that was held June 6-10. Two hundred forty-eight attended the first seminar.

16. On April 27, Nesbo, Hruska, and Refsland presented an overview of the project to 135 participants at the annual conference of the Montana Gerontology Society held in Lewistown.

17. On May 5, Refsland discussed the project implementation plan with Nancy Wartow, Project Officer, Administration on Aging, U.S. Department of Health and Human Services, in Washington, D.C.

18. On August 1, Refsland notified by letter 738 mental health professionals of the scheduled second seminar, "Psychosocial Assessment Strategies Applicable to Aging," that was held September 12-15. One hundred and ninety-eight individuals attended the second seminar.

19. On September 1, Refsland notified by letter 738 mental health professionals of the third seminar, "Diagnosis and Treatment of Depression in the Elderly," that was held October 11 and 13. One hundred and thirty individuals attended the third seminar.

20. On September 8, Refsland discussed the project during a summary meeting with 32 chairmen of topic areas for the Governor's project, "Montana Aging Policy Perspectives: 1990," in Helena. Mental Health Care was one of 32 topic areas scheduled for in-depth discussion and recommendation for policy considerations.

21. On September 8, Refsland discussed the status of the project with the five directors of Montana's Community Mental Health Centers and members, Montana Council of Mental Health Centers, and discussed the first three Public Service Announcements for their appraisal.

22. On September 15, Refsland notified by letter 738 mental health professionals of the statewide conference, "Improving Mental Health Care Services to Montana's Elderly: New Strategies and Solutions to Enduring Problems." Fifty-four individuals attended the Conference on November 18 in Helena.

23. On September 22, Refsland and Nesbo presented the project to approximately 40 participants at the annual Governor's Conference on Aging in Billings. In addition, a problem statement and preliminary recommendations on the mental health problems and solutions were distributed to over 500 participants during the Conference.

24. On November 6, the first 28-minute videotape, "Mental Health Problems of Older Adults," was broadcast via KUSM public broadcasting television in Montana.

25. On December 6, Refsland showed the 12 Public Service Announcements videotapes to 30 Indian participants at a Title IV-A Minority training workshop that was held in Billings.

26. On January 3, 1989, Refsland notified by letter 738 mental health professionals of the fourth seminar, "Loss and Grief as Related to the Aging

Population," that was held February 6-10. A total of 245 mental health professionals attended the fourth seminar.

27. On January 20, Del Straub, Research Associate, Montana Center of Gerontology, discussed the project and showed the first videotape and the 12 Public Service Announcements to 83 participants at the Montana Chapter, National Association of Social Workers, workshop on Validation Therapy held in Bozeman.

28. On February 2, Nancy Wartow, Project Officer, Administration on Aging, discussed the project and showed the Public Service Announcements to the other recipients of discretionary mental health grant awards at a meeting in Washington, D.C. As a result of the discussion, the Public Service Announcements and the two videotapes, including "Mental Health Problems of Older Adults" and "Network of Mental Health Services for Older Montanans," were sent to the National Association for Hispanic Elderly, Los Angeles, the State Unit on Aging, Portland, and the Extension Service, Oregon State University, Corvalis, Oregon for their use.

29. On March 21, in Baker, April 3, in Three Forks, and April 5, in Big Timber, Refsland discussed the project and showed the Public Service Announcements to participants at Title IV-A Interorganizational seminars. Eighteen participants in Baker, 21 in Three Forks, and 25 in Big Timber viewed the PSAs.

30. On April 18, 19, and 20, Straub presented the results of the compilation of data regarding the mental health problems of older Montanans to 220 participants at the annual meeting of the Montana Gerontology Society in Billings.

31. On June 3, Refsland and Nesbo showed the first videotape and 12 Public Service Announcements to seven participants at a conference, "Creating New Directions," of the Montana Alliance for the Mentally Ill in conjunction with the Mental Health Association of Montana, The Regional Councils of Mental Health Centers, and the State Department of Institutions in Billings.

32. On August 4 and 5, Nesbo showed the first videotape and 12 Public Service Announcements to six participants at the 1989 Annual Conference of the Rocky Mountain Council of Community Mental Health Centers in Cody, Wyoming.

33. The 12 Public Service Announcements were distributed to Montana's 14 television stations, including one public broadcasting station. The announcements were aired as follows: (1) Leisure and Recreation for Mental Well-Being in September 1988; (2) Depression in October; (3) Alcoholism in November; (4) Loss and Grief in December; (5) Elder Abuse/Self Neglect in January 1989; (6) Native American Elderly in February; (7) Network of Mental Health Services in March; (8) Suicide in April; (9) Alzheimer's Disease in May; (10) Dementia in June; (11) Substance Abuse in July; and (12) Intergenerational Relations as a Positive Response to Aging in August.

34. The first videotape, "Mental Health Problems of Older Adults," was distributed in November 1988 and the second videotape, "Network of Mental Health Services for Older Montanans," was distributed in December to the five Center Assistants. These videotapes were utilized in 55 county and three federal Indian reservation informational seminars about mental health issues and the elderly.

35. Beginning in October 1988 and ending in October 1989, 55 county and three federal Indian reservation seminars were conducted on the mental health care issues of the elderly. A total of 1537 individuals attended the seminars.

36. Seventy thousand brochures were distributed to Montanans through 56 county welfare offices, 11 area agencies on aging, five community mental health centers, 136 senior centers, 106 long-term-care facilities, 56 public health offices, 65 hospitals, and to 2250 recipients of the Montana Area Health Education Center's Newsletter.

37. Quarterly progress reports were distributed to the following: Administration on Aging, Washington, D.C. and Denver; the five community mental health center directors and center assistants; Governor's Coordinator and two members of the Governor's Advisory Council on Aging; State Executive on Aging; and one director, Area Agency on Aging.

38. Plans for further dissemination of project results include:

A. Distribution of the 12 newspaper articles to 15 daily and 72 weekly newspapers in the State during January 1990. In addition, the 17 aging newspapers will be sent the articles for publishing.

B. Utilization of the 12 PSAs and two videotapes in Title IV-A Seminars and a proposed one-half hour weekly scheduled public service broadcasting (KUSM) television show for Montana.

C. Encouragement of the television stations to continue to air the 12 PSAs.

D. Utilization of compiled data and recommendations with the Montana Aging Policy Perspectives: 1990 project scheduled for further discussion on December 11; Legacy Legislature; and the Montana State Legislature.

E. Further distribution of 30,000 mental health brochures via the "Aging Network."

F. Distribution of the final report to: the Regional Director, Administration on Aging, Denver; the State Executives, State Units on Aging, in Montana, North and South Dakota, Wyoming, Colorado, Utah, and New Mexico; Geriatric Education Centers in Washington and Utah; Montana's 11 Area Agencies on Aging; Montana's Departments of Institutions, Social and Rehabilitation

Services, and Family Services; Indian Health Service; five Community Mental Health Centers; Governor's Office and Advisory Council on Aging; National Institute of Mental Health; National Center for American Indian and Alaska Native Mental Health; National Council on Aging; National Council of Community Mental Health Centers; and National Mental Health Association.

EXECUTIVE SUMMARY

Montana's Department of Family Services (State Unit on Aging), Billings Community Mental Health Center, Montana Area Health Education Center, and the Montana Center of Gerontology, Montana State University developed under the 1987 Coordinated Discretionary Funds Program 2.1.D. a 22-month statewide public education campaign designed to promote better mental health among Montana's elderly, including off-reservation and on-reservation Indian elders: "Improving Mental Health Care Services to Montana Elders: New Strategies and Solutions to Enduring Problems." The overall goal of the project was to initiate a statewide public education campaign intended to convey information to all Montanans regarding symptoms of mental health problems characteristic of the elderly and to provide information that will help them obtain assistance.

There were at least four important reasons why Montana's mental health professionals and the general public must become better informed about the mental health needs of the elderly: (1) Montana's population of elderly, representing 126,100, or 16.2% of the population, is increasing in both absolute numbers and proportionately; (2) since the mental health care system, as it is presently organized, funded, and publicized, has not met all needs of the elderly, further inquiry into the underlying reasons is necessary; (3) treatment modalities and attitudes of some of Montana's mental health professionals must be changed; and (4) Montana's elderly are often "rugged individualists," spatially isolated from mental health services, and are often disinclined to use any service that appears to be government charity, particularly from an agency that treats the mentally ill.

Because one of the most important challenges facing Montana's gerontological service providers is the provision of appropriate and effective care for elderly persons experiencing emotional or cognitive distress and because Montana elderly were in need of mental health services and were currently underserved by the mental health care system, initial preparation for the project consisted of compiling statistics from the five Community Mental Health Care Centers and Indian Health Service about the number and mental health care problems typical of Montana elderly. The public awareness campaign was designed to meet five major objectives: (1) define content for the four one-day quarterly regional seminars; (2) deliver four regional seminars at five locations in the State; (3) prepare two 28-minute broadcast-quality videotapes, one informational brochure, 12 30-60-second public service announcements, and 12 newspaper articles about mental health care; (4) deliver informational seminar regarding mental health care problems and resources to 56 counties and seven federal Indian reservations in Montana; and (5) convene a statewide conference on the mental health care problems of the elderly.

Montana's five Community Mental Health Centers serve 52 of 56 Montana counties. The 1987 Montana older adult population 60 years of age or older was 126,100. This represents 16.2% of Montana's general population. In addition, an estimated 4800 Native Americans aged 60 years of age and older

reside on seven federal Indian reservations in Montana. The five centers and their 26 satellite locations, from October 1, 1986 through September 30, 1987, served 15,911 unduplicated clients. Nine hundred and seventy of the clients were 60 years of age or older, representing 6% of the total caseload of the mental health centers. The 6% is consistent with the National Institute of Mental Health national average of client utilization of mental health centers over 60 caseload. The Indian Health Service, during the same period of time, served 123 (2.5%) Native Americans 60 years of age or older. Thus, .009% of the elderly 60 years of age or older in Montana were served by the centers and Indian Health Service.

The statistical analysis was intended to provide a compilation of data regarding the utilization of Montana's five Community Mental Health Centers and the Indian Health Service for fiscal year 1986-1987 in order to determine the extent of service utilization and to define diagnostic trends and frequencies of specific diagnoses among the Montana elderly.

Thirty-nine percent of all clients served by Montana's Community Mental Health Centers and Indian Health Service were males, with 61% females. Seventy-three percent of the clients were between 60 to 75 and 25% were 75 years of age or older. The nine categories receiving the highest number of diagnoses for all elderly Montanans, in order of frequency, are the following: (1) 177 diagnoses or (18%), as Adjustment Problems; (2) 164 diagnoses or (17%), Major Depressive; (3) 122 diagnoses or (13%), Schizophrenia; (4) 86 diagnoses or (9%), Dysthemia; (5) 72 diagnoses or (7%), Primary Degenerative Dementia; (6) 47 diagnoses or (5%), Personality and Other Impulse; (7) 44 diagnoses or (5%), Anxiety; (8) 43 diagnoses or (4%), Bipolar Disorder; and (9) 40 diagnoses or (4%), Other Organic Mental Disorder.

The number one and two mental health problems for all males seen by the mental health centers are major depressive disorders and adjustment disorders respectively. Adjustment disorders, followed by major depressive disorders, are the top tow mental disorders of Montana's elderly women.

Between the ages of 60 and 74, the number one mental health problem is major depression and, over 74 years of age, the major mental health problem is adjustment disorders.

Of the 123 diagnoses for reservation Indians 60 years of age and older, the most reoccurring category was Other Non-Psychotic Adult and Pre-Adult disorders, 34 diagnoses or 28% of all diagnoses. Others frequently diagnosed were Non-Alcoholic or Non-Drug-Related Organic Disorders, 18 diagnoses or 15%, Schizophrenia and Related disorders, 18 diagnoses or 15%, Substance/Drug Related disorders, 17 diagnoses or 14%, and other Psychotic disorders, 17 diagnoses or 14%. Only the top four problems are rated due to the low number of diagnoses in other categories. Also, caution should be exercised when interpreting all of the data due to the low frequency count (123 cases) reported and the widely variable qualifications of diagnosticians at the treatment sites.

To meet the immediate educational needs of licensed mental health

professionals and to update their knowledge base, a letter and questionnaire was mailed to each of the 738 mental health professionals requesting that they identify the four most interesting topic areas they would like to see addressed in the four one-day seminars. Two-hundred and forty-three (33%) questionnaires were returned.

Representatives from the Indian Health Service, Public Health Service, Governor's Advisory Council on Aging, State Unit and Area Agencies on Aging, State Mental Health Authority, and five Community Mental Health Centers determined that the most often requested and appropriate topics for the four one-day quarterly seminars would be as follows: (1) Review of Normal Aging: A Baseline for Assessing Mental Health Problems of the Elderly; (2) Assessment Strategies Applicable to the Aging: Measurement of Physical Functioning, Mental Status, and Multidimensional Measures; (3) Diagnosing and Treating Depression in the Elderly; and (4) Intervention Strategies with Bereavement, Grieving, and Object Loss as Mental Health Issues of Aging.

Once the content of the regional seminars was determined by taking into account results of the educational needs assessment, the first of the four one-day seminars was organized and conducted.

Two hundred and forty-eight mental health professionals attended the first one-day seminar, "Review of Normal Aging: A Baseline for Assessing Mental Health Problems of the Elderly," held June 6, 7, 8, and 9 in five locations in the State. The participants improved their ability to: (1) identify and describe the normal changes which come with age and (2) assess individual and family functioning in later years. In addition, they enhanced their understanding of: (1) the normal physiological changes that occur in old age; (2) normal cognitive changes that occur in old age; (3) common psychological issues confronted by the elderly; (4) guidelines for distinguishing normal aging from pathological conditions; (5) common dynamics which affect families of the elderly; and (6) adaptive and dysfunctional family dynamics.

One hundred and ninety-eight mental health professionals attended the second one-day seminar, "Psychological Strategies Applicable to the Aging," held September 12, 13, 14, 15, and 16 in five locations in the State. The participants enhanced their knowledge of: (1) factors that need to be considered in a psychological assessment of older adults; (2) observable indicators of disability; (3) assessment tools used in evaluating dysfunction in older adults; (4) Uses of DSM-III-R for diagnosis. In addition, the participants improved their ability to: (1) interview older adults; (2) assess the older adult dysfunction; and (3) translate knowledge concluded from an assessment into a treatment plan.

One hundred and thirty mental health professionals attended the third one-day seminar, "Diagnosis and Treatment of Depression in the Elderly," held October 11 and 13 in two locations in the State. The participants enhanced their knowledge of: (1) epidemiology and phenomenology of depression in the elderly; (2) spatial conditions associated with depression in the elderly: depression complicating cerebrovascular and

neurogenerative disorders; (3) evaluation of depression; (4) neurodiagnostic tests: the separation of depressive pseudodementia and depression; (5) treatment of depression in the elderly; and (6) case presentation and discussion of the treatment of depression in the elderly.

Two hundred and forty-five mental health professionals attended the fourth one-day seminar, "Loss and Grief as Related to the Aging Population," held February 6, 7, 8, 9, and 10 in five locations in the State. The participants enhanced their knowledge of: (1) age-related differences with bereavement; (2) emotions of grief; (3) normal versus abnormal grief; (4) healing process; and (5) program approaches. In addition, the participants improved their skills in: (1) assessing the difference between healthy and unhealthy grief; (2) identifying which people need extended therapy; and (3) helping people work through the grief process.

Two 28-minute videotapes were produced and utilized in the county and federal Indian reservation seminars and other presentations, including the airing on KUSM Montana's Public Service Broadcasting station and other workshops and conferences. The first videotape, "Mental Health Problems of the Older Adults," and the second, "Network of Mental Health Services for Older Montanans," focus on the general mental health problems of the elderly and Montana's mental health care system, emphasizing all resources including the relationship and referral system of the Title III network, Public Health Service, Mental Health Service, and Indian Health Service.

Seventy thousand informational brochures have been distributed. Another 30,000 brochures will be distributed in 1990. The brochures identify some problems for which older adults seek help at Montana's Community Mental Health Centers and the services commonly provided. In addition, the communities in which mental health centers or satellite offices are located and their telephone numbers are listed.

Twelve 30-60 second public service announcements and 12 newspaper articles were prepared for distribution. The 12 public service announcements were distributed to Montana's 14 television stations, including one public broadcasting station. The announcements were aired as follows: (1) Leisure and Recreation for Mental Well-Being, September 1988; (2) Depression, October; (3) Alcoholism, November; (4) Loss and Grief, December; (5) Elder Abuse/Self Neglect, January 1989; (6) Native American Elderly, February; (7) Network of Mental Health Services, March; (8) Suicide, April; (9) Alzheimer's Disease, May; (10) Dementia, June; (11) Substance Abuse, July; and (12) Intergenerational Relations as a Positive Response to Aging, August. The 12 newspaper articles will be distributed to the 15 daily and 72 weekly newspapers in January 1990. In addition, 17 Title III aging newsletters will be sent the articles for publication.

One thousand five hundred and thirty-seven individuals attended 55 county and three federal Indian reservation half-day seminars. Mental health professionals from the five mental health centers and the 26 satellite offices, in cooperation with the directors, Area Agencies on Aging and the local Information and Referral Technicians, were responsible for conducting the county and reservation seminars. The seminars were designed

around viewing the two 28-minute videotapes, presentations by the mental health professional and other technical resource people on the mental health needs of the elderly and effectively accessing the local mental health system network, and concluded with a question-and-answer period.

Fifty-four participants attended the statewide conference, "Improving Mental Health Care Services to Montana's Elderly: New Strategies and Solutions to Enduring Problems." The participants enhanced their understanding of: (1) Montana's mental health system; (2) the mental health problems of older adults; (3) mental health services for older adult data compilation: an in-process review of outpatient diagnosis and demographic survey data for Montana's community mental health service regions; (4) screening the mentally ill in nursing homes as required by the Nursing Home Reform Act (OBRA '87); and (5) preliminary legislative concerns of Montana's mental health care system. In addition, the conference participants identified strategies and recommendations for policy and program considerations, which includes the following questions and the top two priorities identified by participants: (1) What ideas do you have for increasing funding to the Community Mental Health Centers? 1. Increase the federal/state financial obligation to Mental Health Centers by covering case management, transitional living, and raising psychiatric rates under Medicaid, and 2. Provide monetary incentives to enhance deinstitutionalization and maintain the seriously ill in the communities by such means as funding the Montana State Hospital through the Mental Health Centers. For example, each region would have a number of reserved beds at the hospital and, when a seriously mentally ill patient was admitted to Warm Springs, the Mental Health Center in the region where the patient resided would pay the bill; (2) What ideas do you have that would improve interagency cooperation in providing mental health care services to older adults? 1. Modify confidentiality status to facilitate information exchange among professionals regarding services they could provide to individuals, and 2. Establish a realistic form of financing; (3) What ideas do you have for developing collaborative relationships between the Community Mental Health Centers and other service providers? 1. Establish a local council of service providers that would identify community-wide issues and establish commitments among providers so as to ensure continuity of service, and 2. Local workshops should be provided for service providers to educate them about the full range of available services; (4) What ideas do you have for political and legal changes in Montana's legislative policy? 1. More preventive services from mental health agencies through public education. These services should be funded, and 2. Better funding through Medicaid and private insurance for mental health services; and (5) What ideas do you have for delivering mental health services to older adults more creatively? 1. Promoting community awareness of mental health problems through a variety of means, and 2. Education and training for other kinds of disciplines working in aging services. The recommendations will be considered by the Governor of Montana and his Advisory Council on Aging and will be further discussed, considered, and developed for legislative action and implementation.

In conclusion, while 10% of older Montanans have symptoms of emotional distress, only .015% ore being treated by mental health professionals and

only .009% of these are availing themselves of the Community Mental Health Centers. This project was developed with the conviction that licensed mental health professionals would benefit by availing themselves of educational seminars on mental health topics and issues and aging; that the public, including eligible or troubled elderly, would benefit from seeing and reading about these mental health problems; that discussions of local communities would further the provision of an integrated system of services to the older adult; and that the elderly, their children, and service providers would recognize the symptoms of mental illness and effectively refer and more frequently access the Community Mental Health Centers and Indian Health Service.

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INTRODUCTION

The Community Services Division, Montana Department of Family Services (State Unit on Aging), and the Mental Health Center, Billings, submitted an application, "Improving Mental Health Care Services to Montana's Elders: New Strategies and Solutions to Enduring Problems," on December 12, 1986, under the fiscal year 1987 Coordinated Discretionary Funds Program 2.1.D to develop a 17-month pilot statewide public education campaign designed to promote better mental health services among Montana's elderly, including off-reservation and on-reservation Indian elders. The application was conceptualized and developed by Gary A. Refsland, Director, Montana Center of Gerontology, in collaboration with representatives from Montana's 11 Area Agencies on Aging, the Indian Health Service, the Departments of Health and Environmental Sciences (Public Health Service) and Institutions (State Mental Health Authority responsible for the five mental health centers), Montana State University's Area Health Education Center, the Montana Mental Health Association, the Council of Community Mental Health Centers, and the Governor's Office and Advisory Council on Aging. The application was approved on September 28, 1987 by Carol Fraser Fisk, Commissioner, Administration on Aging, U.S. Department of Health and Human Services.

One of the most important challenges facing Montana's gerontological service providers is the provision of appropriate and effective care for elderly persons experiencing emotional or cognitive distress. The need for geriatric mental health services was thoroughly identified and defined in the report, "Mental Health Services for the Elderly: Report on a Survey of Community Mental Health Centers, Volume 1." The report states, "The President's Commission on Mental Health (1978), for instance, found that 15% to 20% of the nation's elderly - between 3.7 and 6.0 million individuals- have significant mental health problems, and they estimated that up to 30% of this older population experiences some form of depressive symptomatology (White House Conference on Aging, 1982). While the elderly comprise 11.3% of the 1980 population, they committed 16.9% of the nation's suicides (McIntosh, 1983; McIntosh, Hubbard, and Santos, 1981). Alcoholism among the elderly is estimated at 8-16% (Kay and Bergman, 1980), and between 50-75% of the nation's nursing home residents manifest emotional or behavioral dysfunction (White House Conference on Aging, 1982). What is particularly unfortunate about the lack of mental health services to the aged is that many of these problems could be successfully treated on an outpatient basis."

The results of that study prompted Arthur Flemming, Chair of the Action Committee, which was charged to implement mental health recommendations for the 1981 White House Conference on Aging, to write to Montana Governor Ted Schwinden and other governors about concerns relative to the Committee's charge. In his letter, he reaffirmed the fact that the aged are underserved, receiving less than half the level of services that would be expected based on their percentage of the population, that there is little interaction and almost no routine cooperation between mental health centers and area agencies on aging, and that outreach programs to the aged are almost non-existent.

The report and the letter encouraged the State Agency on Aging to become more familiar with mental health problems of the elderly, and the mental health centers and to further develop better cooperative relationships with them. As a result, the process of sharing training activities, providing mental health centers an opportunity to become more visible to the "Aging Network," providing opportunities for the "Aging Network" to be more visible to the mental health centers, and improving communication was begun.

Discussions with directors of the centers and State department representatives revealed a low rate of utilization of mental health centers by Montana elderly. In addition to the low rate of use noted for mental health care delivery by Montana elderly, a qualitative deficiency also existed. As Levinson (1983) stated, "Qualitatively, a therapeutic nihilism underscores their treatment. The proponents of such nihilism espouse the view that because old age is irreversible, late-life illnesses are likewise beyond significant assistance. As a consequence, psychopharmacological control and palliative measures often form the mainstay of treatment, with inadequate efforts directed to producing remissions in reversible states and to optimal rehabilitation. In fact, in skilled and caring hands, what is reversible in younger adult populations is likewise reversible in the aged. Suboptimal technique practiced in younger populations will generally find its way to the elderly, but with greater consequences."

Nationwide there is a lack of preventive mental health and wellness programs for the elderly. Agistic views among physicians and the general population may prevent recognition and treatment of mental health problems in the elderly. Some people convey the attitude that mental health problems are just an inevitable part of aging.

Given the high rate of short-term and reversible mental health problems characteristic for the older population, it was expected that the elderly would appear as a significant proportion of the outpatient clientele served by the five community mental health centers in Montana and their 26 satellite outpatient mental health facilities. Unfortunately, with the exception of the Mental Health Center in Billings, that was not the case. The Mental Health Center delivered 94,654 total units of service during 1986, with the 55 years of age and over and transitional living accounting for only 16,664 (17.6%) of total units registered. This percentage, which was higher than that for the other four centers, was attributed to the Billings Older Adult Services Program.

At the time of grant preparation, recent statistics for estimating any increase in the utilization by the elderly of mental health care in Montana were unavailable due to different reporting procedures and conversion to a computerized data base by the mental health centers. National data provided by the National Institute of Mental Health show that the percentage of elderly community mental health center clients did increase slightly from 1971 to 1982, from 3.4% to 6%. However, this rate is still well below the 11.3% expected solely on the basis of the relative proportion of elderly clients in the general population. Since the percentage of older persons

with some type of mental-related problem has been estimated to be approximately 25% (President's Commission on Mental Health 1978), the achieved 6% is even more serious that it might appear on a strictly demographic basis alone.

Thus, there were at least four important reasons why Montana's mental health professionals and the general public must become better informed about the mental health needs of the elderly: (1) Montana's population of elderly, representing 126,100, or 16.2% of the population, is increasing in both absolute numbers and proportionately; (2) since the mental health care system, as it is presently organized, funded, and publicized, has not met all needs of the elderly, further inquiry into the underlying reasons is necessary; (3) treatment modalities and attitudes of some of Montana's mental health professionals must be changed; and (4) Montana's elderly are often spatially isolated from mental health services and are often disinclined to use any service that appears to them to be government charity, particularly from an agency that treats the mentally ill. These conditions suggested the need for: (1) expanding outreach programming; (2) developing a public awareness campaign to revise the currently unsatisfactory image of mental health care centers; (3) meeting progressive increases in demand for mental health services by those elderly who have relatively greater mental health problems, few of whom have resources to meet those needs; and (4) expanding the roles of informed mental health professionals such as psychiatrists, social workers, psychologists, and nurses in the mental health treatment of Montana's elderly.

METHODOLOGY

Because Montana elderly were in need of mental health services and were currently undeserved by the mental health care system, this project was designed to initiate a statewide public education campaign intended to convey information to all Montanans regarding symptoms of depression, stress, and other mental health problems characteristic of the elderly and to provide information that would help the elderly to obtain assistance. Initial preparation for the project consisted of compiling statistics from the five Community Mental Health Centers and Indian Health Service about the number, units of service, and mental health care problems typical of Montana elderly. The public awareness campaign consisted of completing five major objectives:

1. Define Content for the Four One-Day Quarterly Regional Seminars;
2. Deliver Four Regional Seminars at Five Locations in the State;
3. Prepare Two 28-minute Broadcast-Quality Videotapes, One Informational Brochure, 12 Public Service Announcements, and 12 Newspaper Articles about Mental Health Care;
4. Deliver Informational Seminar Regarding Mental Health Care Problems and Resources to 56 Counties and Seven Federal Indian Reservations in Montana.
5. Convene a Statewide Conference on the Mental Health Care Problems

of the Elderly.

Compilation of Data on Use of Mental Health Centers by Montana Elderly

Montana's five Community Mental Health Centers located in Miles City, Billings, Great Falls, Helena, and Missoula serve 52 of 56 counties. The five centers and their 26 satellite locations, from October 1, 1986 through September 30, 1987, served 970 clients 60 years of age or older. The Indian Health Service, during the same period of time, served 123 Native Americans 60 years of age or older. Thus, .009% of the elderly 60 years of age or older in Montana were served by the centers and Indian Health Service during that period.

The statistical analysis was intended to provide a compilation of data regarding the utilization of Montana's five Community Mental Health Centers and the Indian Health Service for fiscal year 1986-1987 in order to determine the extent of service utilization and to define diagnostic trends and frequencies of specific diagnoses among the Montana elderly.

The 1987 population estimates for older adult Montanans, aged 60 and over, were derived using an age-sex cohort survival model developed by the Bureau of Business and Economic Research, University of Montana, Missoula (see Figure 3).

This general methodology is summarized as follows. The 1980 Census estimate for each age category was survived through the next year using actual single-year-of-age deaths. Births were then added to include those less than one-year old. This population was then summed to derive a total population without migration. Migration was estimated by determining a residual of the derived estimate. The total net migration was then distributed to each age group by allocating the migration using age-specific migration rates. This process was accomplished for each year, in this case through 1987, until a new census total population count becomes available in 1990. In addition, 1987 basic source data on population estimates for the Crow, Fort Belknap, Rocky Boy, Blackfeet, Fort Peck, and Northern Cheyenne federal Indian reservations was provided by the Bureau of Indian Affairs, Billings and the Bureau of Indian Affairs, Portland, provided population estimates for the Flathead Indian reservation for 1987. Synthesis of source data was accomplished by the Montana Center of Gerontology, Montana State University. The use of other source data might yield other estimates.

The 1987 Montana older adult population 60 years of age or older was 126,100. This represents 16.2% of Montana's general population, an increase of 1% for this age cohort over the 1980 census figures (see Figure 4). In addition, an estimated 4800 Native Americans aged 60 years of age and older reside on federal Indian reservations in Montana.

The base data from which this report was formulated were submitted by the five Montana Community Mental Health Centers located in Helena, Miles City, Billings, Missoula, and Great Falls (Figure 1). Similar information was submitted by the Indian Health Service. Data submitted by the centers for fiscal year 1986-1987 consisted of patient information regarding sex,

age, race, county of residence, and clinical diagnostic code.

Reports received from the centers presented potential challenges in regard to data collection and analysis. Although each center and the Indian Health Service maintains similar basic data on their patients, they use a different format and datum "shorthand" by which to electronically file information. There are, for example, three different ways in which age was recorded and two different ways each for race, sex, and county of residence. Additionally, three different diagnostic coding systems are presently being utilized. These include DSM-III, DSM-III-R, and ICD-9-CM. The first task was to develop a uniform format for the data input and to convert all data to some common "language" that could facilitate subsequent analyses.

The relatively low, approximately 1000, Community Mental Health Center patient density for the State allowed for the manual, but time-consuming, conversion of the information elements (age, sex, race, and county) to a common input language. Conversion of diagnostic codes into a common coding system, however, was more difficult since no common "language" of mental health diagnoses exists. A telephone conversation with Mr. Paul Henderson, Data Systems Analyst, National Institute of Mental Health (telephone 301-443-3683), revealed that similar problems had been encountered by the National Institute of Mental Health and the Department of Health and Human Services during attempts by clinicians and researchers in the United States to gather national DSM-III and DSM-III-R. All federal agencies and many states adhere to a policy supporting the use of ICD-9-CM.

In 1980, a "crosswalk" between DSM-III and ICD-9-CM was developed in a joint effort by the Health Care Financing Administration, the National Center for Health Statistics, and the National Institute of Mental Health (Thompson 1983). The crosswalk was designed to be used in several different ways:

First, in the medical records room, it provides a standard means of converting DSM-III codes by clinicians to the ICD-9-CM codes required by federal agencies and many state statistical systems; second, it assists systems analysts and survey researchers who have a mixture of DSM-III and ICD-9-CM data that must be collapsed into a common data set; and third, it can be used as a guide to the direct use of certain DSM-III codes in federal reporting for reimbursement.

The crosswalk was further modified by the Montana Center of Gerontology to include a crosswalk to the DSM-III-R diagnostic coding system.

Further modification of the basic crosswalk to create a crosswalk between the three diagnostic systems, DSM-III, DSM-III-R, and ICD-9-CM, was accomplished in the following manner. The crosswalk between DSM and ICD-9-CM as developed by Thompson et al, established a basic crosswalk table of codes. The table provided that, in numeric terms, DSM-III equals ICD-9-CM. The Diagnostic and Statistical Manual of Mental Disorders, Third Edition, revised, Appendix D, provides a comparative listing of the diagnostic codes for DSM-III and DSM-III-R. Once again, in numeric terms, DSM-III can be made to closely equal DSM-III-R. Therefore, if DSM-III equals ICD-9-CM and

DSM- III equals DSM-III-R, ICD-9-CM can be made to closely equal DSM-III-R.

This triangulation of systems provided a three-system crosswalk (see Appendix A). It must be emphasized, however, that this crosswalk has not been validated by psychiatric specialists, nor has it been field tested in the manner of the original compilation and systems analysis.

In addition to development of the first basic crosswalk, the National Institute of Mental Health provided a list of diagnostic categories into which all similar diagnostic codes can be electronically sorted. This sorting or "collapsing" process is believed by the Institute to be essential so as to give some meaning to what would otherwise be a patient diagnostic data list so long and detailed that any meaningful management interpretation or analysis would be difficult. The process of collapsing the diagnostic codes into meaningful categories is accomplished as follows (see Figure 2): first, the codes in the diagnostic crosswalk are assigned to 32 diagnostic categories of mental health conditions and diagnoses; and, second, the data for Montana mental health patients (diagnostic code as determined by center clinicians) is electronically sorted using the locally developed crosswalk and then assigned to one of the 32 diagnostic categories.

It is important to remember that this process is of value primarily to systems analysts and for statistical survey and research. It is not meant to be, nor should it be, construed as an acceptable replacement for existing center coding systems. Discrepancies may exist in the crosswalk that would be revealed with extensive field testing and validation. It is believed, however, that any discrepancy in the diagnostic code crosswalk is compensated for by the "generalization" of assignment of diagnostic code groups to the 32 categories of mental health conditions. Additionally, these 32 categories can be further collapsed into 14 final mental health condition categories (see Figure 2). This should further minimize any diagnostic code discrepancies in the code crosswalk. Regardless, any crosswalk discrepancies do not appear to be statistically significant, nor do they alter the validity of the report for providing valuable data to decision and policy-makers regarding mental health issues within the State. Definitions of the 14 categories can be found in Appendix B.

1. Define Content for the Four One-Day Quarterly Regional Seminars

The months of December 1987 and January 1988 saw compilation of the names and addresses of licensed mental health professionals practicing in the five community mental health centers and other public or private organizations in Montana. The compilation included psychiatrists, counselors/therapists, social workers, and geriatric and psychiatric nurses. Included were 738 licensed practicing mental health professionals.

On February 8, a letter and a questionnaire (see Appendix C) was mailed to each of the 738 mental health professionals requesting that they identify the four most interesting topic areas they would like to see addressed in the four one-day seminars. On February 29, these results were tabulated. Two-hundred and forty-three (33%) questionnaires were returned (see Appendix D).

On March 9, representatives from the Indian Health Service, Public Health Service, Governor's Advisory Council on Aging, State Unit and Area Agencies on Aging, State Mental Health Authority, and five community mental health centers attended a one-day meeting in Helena to assist in the definition of content for the four one-day quarterly regional seminars.

Based on the results of the educational needs assessment conducted during the previous quarter, representing 243 (33%) mental health professionals, the representatives determined that the most often requested and appropriate topics for the four one-day quarterly seminars would be as follow:

First Seminar: "Review of Normal Aging: A Baseline for Assessing Mental Health Problems of the Elderly."

Second Seminar: "Assessment Strategies Applicable to the Aging: Measurement of Physical Functioning, Mental Status, and Multidimensional Measures."

Third Seminar: "Diagnosing and Treating Depression in the Elderly."

Fourth Seminar: "Intervention Strategies with Bereavement, Grieving, and Object Loss as Mental Health Issues of Aging."

2. Deliver Four Regional Seminars at Five Locations in the State

Once the content of the regional seminars was determined by taking into account results of the educational needs assessment, the first of the four one-day seminars was organized and conducted. In order to make the most efficient and cost-effective use of resources, the one-day seminars were scheduled for Monday, Tuesday, Wednesday, Thursday, and Friday. Thus, the resource people conducted the seminars during a one week period. In-state resources were identified and out-of-state expertise was identified through the University of Utah and Washington Geriatric Education Centers. Four seminars were presented at each of five Community Mental Health Centers: Missoula, in western Montana; Helena, in west-central Montana; Great Falls, in north-central Montana; Billings, in south-central Montana; and Miles City, covering the eastern part of the State.

On April 25, Refsland mailed to 738 mental health professionals a letter notifying them that the first seminar was scheduled for June 6-10 (see Appendix E).

Speaker for the first seminar, "Review of Normal Aging: A Baseline for Assessing Mental Health Problems of the Elderly," was Dr. Amanda Barusch, Chairman of the Gerontology Emphasis, Graduate School of Social Work, University of Utah. Dr. Barusch conducted the seminar in Missoula on June 6 with 71 participants in attendance; Helena on June 7 with 49 participants; Great Falls on June 8 with 41 participants; and Miles City on June 9 with 46 participants. Speakers at the seminar in Billings on June 9 included: Dr. Victoria Coffman, Professor of Communication Arts, Eastern Montana College;

Mary Freund, R.N., Geriatric Nurse Practitioner, Billings Clinic; and Dr. Judith McLaughlin, Assistant Professor of Psychology, Eastern Montana College. Forty-one participants attended the Billings seminar. Thus, a total of 248 mental health professionals attended the first seminar.

On August 1 an announcement was sent to 738 mental health professionals in the State notifying them that the second seminar was scheduled for September 12-15 (see Appendix F).

Speaker for the second seminar, "Psychosocial Assessment Strategies Applicable to Aging," was Joan Nell, OTR/L MPH, Program Manager, Older Adult Services, Seattle Mental Health Institute. Ms. Nell conducted the seminar in Miles City on September 12 with 28 participants in attendance; Billings on September 13 with 44 in attendance; Great Falls on September 14 with 36 in attendance; Helena on September 15 with 47 in attendance; and Missoula on September 16 with 43 in attendance. Thus, a total of 198 mental health professionals attended the second seminar.

On September 1, Refsland notified 738 mental health professionals of the third seminar scheduled for October 11 and 13 (see Appendix G).

Speaker for the third seminar, "Diagnosis and Treatment of Depression in the Elderly," was Dr. James Slaughter, M.D., Assistant Professor, Department of Psychiatry, University of Utah School of Medicine; Medical Director, Older Adult Evaluation and Treatment Clinic, Western Institute of Neuropsychiatry; and Chief of Consultation Liaison Psychiatry, Veterans Administration Medical Center, Salt Lake City, Utah. Dr. Slaughter conducted the seminar on October 11 in Missoula with 80 participants in attendance and Billings on October 13 with 50 in attendance. Thus, a total of 130 mental health professionals attended the third seminar.

On January 3, Refsland notified by letter 738 mental health professionals of the fourth seminar scheduled for February 6-10, 1989 (see Appendix H).

Speaker for the fourth seminar, "Loss and Grief as Related to the Aging Population," was Ms. Karen L. Kent, M.S.G., Department Manager, Older Adult Services, Eastside Mental Health Center, Bellevue, Washington. Ms. Kent conducted the seminar on February 6 in Miles City with 34 in attendance, February 7 in Billings with 49 in attendance, February 8 in Great Falls with 37 in attendance, February 9 in Helena with 48 in attendance, and February 10 in Missoula with 77 in attendance. Thus, a total of 245 mental health professionals attended the fourth seminar.

3. Prepare Two 28-Minute Broadcast Quality Videotapes, One Informational Brochure, 12 Public Service Announcements and 12 Newspaper Articles About Mental Health Care

The pre-production of the two videotapes and the 12 Public Service Announcements and newspaper articles were initiated as a result of the statewide meeting and completion of Objective Number One. National and state organizations were contacted by telephone to determine whether they

had produced videotapes or PSAs and were asked to provide any reference material that might be utilized in the pre-production phase. Those contacts yielded limited, but some useful materials. The organizations contacted included: National Center for American Indian and Alaska Native Mental Health, Denver; Yakima Indian Nation, Washington; Family Survival Project, San Francisco; National Council on Aging, Washington, D.C.; University of Texas Health Science Center, Houston; National Council of Community Mental Health Centers, Maryland; National Mental Health Association, Virginia; Pennsylvania State University; Public Television Station, Virginia; Alzheimer's Disease and Related Disorders Association, Chicago; and College of Nursing, Montana State University, Bozeman. In addition to the above contacts, a literature review was conducted at Renne Library, Montana State University.

The strategy for pre-production preparation included a literature review, followed by the development of a paper on each topic area. Once the paper was completed, a script and treatment were developed and a draft was distributed to the five center assistants and others for critique. Once approved by the center assistants, production began. The first 28-minute videotape, "Mental Health Problems of Older Adults," focused on the general mental health problems of the elderly and the second 28-minute videotape, "Network of Mental Health Services for Older Montanans," focused on Montana's mental health care system, emphasizing all resources including the relationship and referral system of the Title III Network, Public Health Service, Mental Health Service, and the Indian Health Service.

The production of the two 28-minute videotapes and the 12 public service announcements was the responsibility of the Film and Television Service, Montana State University. The topic areas for the 12 Public Service Announcements and 12 newspaper articles (see Appendix I) include: (1) Leisure and Recreation for Mental Well-Being; (2) Depression; (3) Alcoholism; (4) Loss and Grief; (5) Elder Abuse/Self Neglect; (6) Native American Elderly; (7) Network of Mental Health Services; (8) Suicide; (9) Alzheimer's Disease; (10) Dementia; (11) Substance Abuse; and (12) Intergenerational Relations as a Positive Response to Aging.

The same procedure used in the development of the 12 public service announcements and videotapes was used in the development of the informational brochure. The preliminary information for the brochure was completed and then the proposed brochure was distributed to the center assistants and directors for critique and review. Once approved, the brochures (see Appendix J) were printed and distributed. The brochures were distributed through 56 county welfare offices, 11 area agencies on aging, five Community Mental Health Centers, 136 senior centers, 106 long-term-care facilities, 56 public health offices, 65 hospitals, and to 2250 recipients of the Montana Area Health Education Center's Newsletter.

4. Deliver Informational Seminar Regarding Mental Health Care Problems and Resources to 56 Counties and Seven Federal Indian Reservations in Montana

Mental health professionals from the five mental health centers and the 26 satellite offices, in cooperation with the directors, Area Agencies on

Aging and the local Information and Referral Technicians, were responsible for conducting county and reservation half-day informational seminars.

Because most psychiatric illnesses are first seen and treated by primary care physicians, the mental health professionals were in contact with and included on the agenda, when possible, the local family service practitioner. Also included and invited to attend were the social workers for the community and other community resource people. The half-day session included viewing the videotapes, a presentation by the mental health professional and other technical resources, and a question-and-answer period for participants. Because all Montana counties and reservations have a senior center in which 22% of the elderly participate, and in order to further the concept of a community focal point, the majority of the seminars were conducted in senior centers. The public was invited to attend via local newspaper articles.

The center assistants and 56 county coordinators and the seven federal Indian reservation coordinators convened the informational seminars in the counties and on the Indian reservations.

The following county and reservation seminars were completed:

October 18	Garfield	32 participants
October 26	Lincoln	12 participants
November 9	McCone	40 participants
November 17	Wheatland	20 participants
November 17	Fallon	20 participants
November 19	Glacier	20 participants
November 26	Dawson	40 participants
November 29	Jefferson	20 participants
November 30	Yellowstone	41 participants
November 30	Prairie	38 participants
December 1	Broadwater	17 participants
December 1	Wibaux	24 participants
December 8	Stillwater	52 participants
December 8	Flathead	15 participants
December 8	Missoula	5 participants
December 9	Sweetgrass	41 participants
December 12	Ravalli	7 participants
December 14	Mineral	11 participants
December 15	Judith Basin	32 participants
December 16	McCone	16 participants
December 20	McCone	15 participants
December 21	Meagher	8 participants
January 10	Teton	22 participants
January 11	Carbon	22 participants
January 12	Lewis and Clark	15 participants
January 18	Golden Valley	17 participants
January 19	Petroleum	40 participants
January 23	Blaine	19 participants
January 25	Musselshell	29 participants
January 30	Fergus	16 participants

February 1	Lake (reservation)	8 participants
February 8	Richland	8 participants
February 9	Gallatin	15 participants
February 10	Silverbow	22 participants
February 15	Lake	20 participants
February 15	Powder River	112 participants
February 15	Sanders	40 participants
February 16	Big Horn	20 participants
February 21	Rosebud	37 participants
February 22	Lake (reservation)	40 participants
February 23	Custer	57 participants
February 23	Pondera	25 participants
March 7	Liberty	15 participants
March 8	Roosevelt/Treasure	43 participants
March 9	Valley	41 participants
March 13	Philips	3 participants
March 13	Sheridan	7 participants
March 27	Madison	16 participants
March 27	Cascade	14 participants
March 28	Park	40 participants
March 28	Toole	25 participants
March 29	Hill	61 participants
April 3	Choteau	30 participants
April 24	Daniels	42 participants
May 10	Deer Lodge	Cancelled
May 24	Powell	20 participants
May 25	Granite	20 participants
October 15	Glacier(reservation)	50 participants
	Beaverhead	Declined to participate
	Carter	Declined to participate

5. Convene a Statewide Conference on the Mental Health Care Problems of Montana Elderly

The statewide conference was scheduled for November 18, 1988, in Helena. On September 8, Refsland met with the center directors to discuss the preliminary agenda for the conference. Also, a meeting was scheduled in September with the center assistants to further develop an agenda for the conference.

Fifty-four participants attended the conference (see Appendix K for the conference announcement). Recommendations were developed as part of the day's events. The recommendations were reviewed by the center directors and assistants and are currently being reviewed by the Governor's Advisory Council on Aging and have been included in the Montana Aging Policy Perspectives: 1990 study, for consideration by the Governor of Montana and the congressional delegation.

By utilizing a modified nominal group technique, conference participants were asked to discuss the following questions in their discussion groups and then to prioritize their recommendations for review. Following are the questions and the top priorities identified by

participants:

1. What ideas do you have for increasing the funding to the Community Mental Health Centers? (1) Increase the federal/state financial obligation to Mental Health Centers by covering case management, transitional living, and raising psychiatric rates under Medicaid; (2) Provide monetary incentives to enhance deinstitutionalization and maintain the seriously mentally ill in the communities by such means as funding the Montana State Hospital through the Mental Health Centers. For example, each region would have a number of reserved beds at the hospital and, when a seriously mentally ill patient was admitted to Warm Springs, the Mental Health Center in the region where the patient resided would pay the bill; (3) Mandate participation of all Montana counties in the Mental Health system. In addition, mandate the level of participation at a one mill level; and (4) Close all units at Warm Springs except for the geriatric unit and the forensic unit. Attach the forensic unit to the prison and the geriatric unit to Galen State Hospital. Open three 30-bed or four 25-bed psychiatric facilities in urban areas across the State and place these facilities under the direction of the Mental Health centers in those regions.

2. What ideas do you have that would improve interagency cooperation in providing mental health care services to the older adult? (1) Modify confidentiality status to facilitate information exchange among professionals regarding services they could provide to individuals; (2) Establish a realistic form of financing; and (3) Enable different agencies to recognize that no single provider of services can stand alone.

3. What ideas do you have for developing collaborative relationships between community mental health centers and other service providers? (1) Establish a local council of service providers that would identify community-wide issues and establish commitments among providers so as to ensure continuity of service; and (2) Local workshops should be provided for service providers to educate them about the full range of available services.

4. What ideas do you have for political and legal change in Montana legislative public policy? (1) More preventive services from mental health agencies through public education. These services should be funded; (2) Better funding through Medicaid and private insurance for mental health services; (3) A pilot project based on the Spokane Project Elderly Services which provides for non-traditional forms of intervention; (4) More research, promotion, and advocacy for mental health services to all groups, including the elderly; (5) A commitment to repeal C-18 allowing legislature to determine eligibility and longevity for economic assistance; (6) Long-range planning with goals, objectives, and how to achieve them in terms of mental health programs for the aged; and (7) Legislation giving "right to entry" in reported cases of elder abuse.

5. What ideas do you have for delivering mental health services to older adults more creatively? (1) Promoting community awareness of mental health problems through a variety of means; (2) Education and training for other kinds of disciplines working in aging services; and (3) Providing

treatment at nursing homes, senior centers, and in-home; in other words, out of office.

RESULTS

Data on Use of Mental Health Centers by Montana Elderly

According to the Department of Institutions, the five Community Mental Health Centers from October 1, 1986 to September 30, 1987, served approximately 15,911 unduplicated clients. Nine hundred and seventy of the clients were 60 years of age or older, representing 6% of the total caseload of the mental health centers. According to the Department of Institutions, Miles City's Community Mental Health Center served 2892 clients, and the elderly represented 119 or 4%. Billings recorded a total of 4217 unduplicated clients, with 408 or 10% 60 years of age or older. Helena's unduplicated clients totaled 2597, and 117 were elderly or 5%. Great Falls recorded 3222 clients, with 215 or 7% of their clients 60 years of age or older. The Community Mental Health Center in Missoula served 3156 unduplicated clients, with 111 or 4% of the clients elderly.

During the analyzed period of fiscal year 1987, it was found that less than 1% or 970 Montanans residing off Native American reservations, aged 60 years and older, utilized Community Mental Health Care Centers. During the same period, 2.5% of reservation Native Americans aged 60 years of age and older were treated for mental conditions by the Indian Health Service. These health care utilization figures are striking (if national U.S. norm "needs" estimates are accurate) in that approximately 15-25% of the nation's older adults suffer from some form of mental illness (see Figures 5 and 6).

Thirty-nine percent of all clients served by Montana's Community Mental Health Centers and Indian Health Service were males with 61% females. Seventy-three percent of the clients were between 60 to 75 and 25% were 75 years of age or older.

The nine service categories receiving the highest number of diagnoses for all elderly Montanans, in order of frequency, are the following:

177 (18%) were diagnosed as Adjustment Problems

164 (17%) were diagnosed as Major Depressive

122 (13%) were diagnosed as Schizophrenia

86 (09%) were diagnosed as Dysthemia

72 (07%) were diagnosed as Primary Degenerative Dementia

47 (05%) were diagnosed as Personality and Other Impulse

44 (05%) were diagnosed as Anxiety

43 (04%) were diagnosed as Bipolar Disorder

40 (04%) were diagnosed as Other Organic Mental Disorders

The number one and two mental health problems for all males seen by the mental health centers are major depressive disorders and adjustment disorders respectively. Adjustment disorders, followed by major depressive disorders, are the top two mental disorders of Montana's elderly women.

Between the ages of 60 and 74, the number one mental health problem is major depression and, over 74 years of age, the major mental health problem is adjustment disorders.

Of the 970 diagnoses made on non-reservation older adults, the most frequently reoccurring category of mental condition was some type of affective disorder, which represented 292 diagnoses or 30% of all diagnoses. This was followed in order by: other Non-Psychotic disorders, 189 diagnoses or 19%; Schizophrenic and associated disorders, 136 diagnoses or 14%; Organic Non-drug related diagnoses, 119 diagnoses or 12%; and all other diagnosed disorders, regardless of category represented, 233 diagnoses or 24% (see Figure 7). Data profiles by service regions for Affective Disorders are provided in Figures 8 through 14.

Of the 123 diagnoses for reservation Native Americans age 60 years of age and older, the most reoccurring category was Other Non-Psychotic Adult and Pre-Adult disorders, 34 diagnoses or 28% of all diagnoses. Others frequently diagnosed were Non-Alcoholic or Non-Drug-Related Organic Disorders, 18 diagnoses or 15%, Schizophrenia and Related disorders, 18 diagnoses or 15%, Substance/Drug Related disorders, 17 diagnoses or 14%, and other Psychotic disorders, 17 diagnoses or 14%.

Only the top five problems are rated due to the low number of diagnoses in other categories. Also, caution should be exercised when interpreting all of the data due to the low frequency count (123 cases) reported and the widely variable qualifications of diagnosticians at the treatment sites.

Four Quarterly Regional Seminars

Two hundred and forty-eight mental health professionals attended the first one-day seminar, "Review of Normal Aging: A Baseline for Assessing Mental Health Problems of the Elderly," held June 6, 7, 8, and 9 in five locations in the State. Eighty-one (32%) participants were social workers, 18 (07%) were psychologists, 46 (19%) were registered nurses, 18 (07%) were directors, and 12 (05%) were counselors. Thirty percent (73) of the participants represented other disciplines interested in the mental health seminar. The participants improved their ability to: (1) identify and describe the normal changes which come with age and (2) assess individual and family functioning in later years. In addition, they enhanced their understanding of: (1) the normal physiological changes that occur in old age; (2) normal cognitive changes that occur in old age; (3) common

psychological issues confronted by the elderly; (4) guidelines for distinguishing normal aging from pathological conditions; (5) common dynamics which affect families of the elderly; and (6) adaptive and dysfunctional family dynamics.

One hundred and ninety-eight mental health professionals attended the second one-day seminar, "Psychological Strategies Applicable to the Aging," held September 12, 13, 14, 15, and 16 in five locations in the State. Eleven (06%) participants were counselors, 31 (16%) were registered nurses, and 68 (34%) were social workers. Eighty-eight (44%) represented other disciplines interested in the mental health seminar. The participants enhanced their knowledge of: (1) factors that need to be considered in a psychological assessment of older adults; (2) observable indicators of disability; (3) assessment tools used in evaluating dysfunction in older adults; and (4) Uses of DSM-III-R for diagnosis. In addition, the participants improved their ability to: (1) interview older adults; (2) assess the older adult dysfunction; and (3) translate knowledge concluded from an assessment into a treatment plan.

One hundred and thirty mental health professionals attended the third one-day seminar, "Diagnosis and Treatment of Depression in the Elderly," held October 11 and 13 in two locations in the State. Fifteen (12%) participants were counselors, 22 (17%) were nurses, and 25 (19%) were social workers. Sixty-eight (52%) participants represented other disciplines interested in the mental health seminar. The participants enhanced their knowledge of: (1) epidemiology and phenomenology of depression in the elderly; (2) spatial conditions associated with depression in the elderly: depression complicating cerebrovascular and neurodegenerative disorders; (3) evaluation of depression; (4) neurodiagnostic tests: the separation of depressive pseudodementia and depression; (5) treatment of depression in the elderly; and (6) case presentation and discussion of the treatment of depression in the elderly.

Two hundred and forty-five mental health professionals attended the fourth one-day seminar, "Loss and Grief as Related to the Aging Population," held February 6,7,8,9, and 10 in five locations in the State. Twenty-four (10%) participants were counselors, 35 (14%) were registered nurses, and 59 participants were social workers. One hundred and twenty-seven (52%) represented other disciplines interested in the mental health seminar. The participants enhanced their knowledge of: (1) age-related differences with bereavement; (2) emotions of grief; (3) normal versus abnormal grief; (4) healing process; and (5) program approaches. In addition, the participants improved their skills in: (1) assessing the difference between healthy and unhealthy grief; (2) identifying which people need extended therapy; and (3) helping people work through the grief process.

A total of 821 mental health professionals attended the four quarterly one-day seminars: 16 (2%) therapists, 219 (27%) social workers, 21 (3%) directors, 62 (8%) counselors, and 15 (2%) clinical social workers. Four hundred and eighty-eight (59%) represented other disciplines involved in mental health and the elderly (see Appendix L).

Videotapes, Brochure, Public Service Announcements, and Newspaper Articles

Two 28-minute videotapes were produced and utilized in the county and federal Indian reservation seminars and other presentations, including the airing on KUSM Montana's Public Service Broadcasting station and other workshops and conferences. The first videotape, "Mental Health Problems of Older Adults," and the second, "Network of Mental Health Services to Older Montanans," focus on the general mental health problems of the elderly and Montana's mental health care system, emphasizing all resources including the relationship and referral system of the Title III network, Public Health Service, Mental Health Service, and Indian Health Service.

Seventy thousand informational brochures have been distributed. Another 30,000 brochures will be distributed in 1990. The brochures identify some problems for which older adults seek help at Montana's Community Mental Health Centers and the services commonly provided. In addition, the communities in which mental health centers or satellite offices are located and their telephone numbers are listed.

Twelve 30-60 second public service announcements and 12 newspaper articles were prepared for distribution. The 12 public service announcements were distributed to Montana's 14 television stations, including one public broadcasting station. The 14 television stations cover the entire State of Montana and northern Wyoming. The announcements were aired as follows: (1) Leisure and Recreation for Mental Well-Being, September 1988; (2) Depression, October; (3) Alcoholism, November; (4) Loss and Grief, December; (5) Elder Abuse/Self Neglect, January 1989; (6) Native American Elderly, February; (7) Network of Mental Health Services, March; (8) Suicide, April; (9) Alzheimer's Disease, May; (10) Dementia, June; (11) Substance Abuse, July; and (12) Intergenerational Relations as a Positive Response to Aging, August. The 12 newspaper articles will be distributed to the 15 daily and 72 weekly newspapers in January 1990. In addition, the 17 Title III aging newsletters will be sent the articles for publication.

County and Federal Indian Reservation Seminars

One thousand five hundred and thirty-seven individuals attended 55 county and three federal Indian reservation half-day seminars convened by the five center assistants and representatives of the 26 satellite offices of the Community Mental Health Center and Indian Health Service network. The seminars began in October 1988 and concluded in October 1989. The half-day sessions were designed around viewing the two 30-minute videotapes, "Mental Health Problems of Older Adults" and "Network of Mental Health Services for Older Montanans," presentations by the mental health professional and other technical resource people on the mental health needs of the elderly and effectively accessing the local mental health system network, and concluded with a question-and-answer period.

Statewide Conference on Mental Health Care Problems of the Elderly

Fifty-four participants attended the statewide conference, "Improving Mental Health Care Services to Montana's Elderly: New Strategies and

Solutions to Enduring Problems," held in Helena on November 18, 1989. The participants enhanced their understanding of: (1) Montana's Mental Health System; (2) the mental health problems of older adults; (3) mental health services for older adult data compilation: an in-process review of outpatient diagnosis and demographic survey data for Montana's community mental health service regions; (4) screening the mentally ill in nursing homes as required by the Nursing Home Reform Act (OBRA '87); and (5) preliminary legislative concerns of Montana's mental health care system.

In addition, the participants worked in five small discussion and exchange groups utilizing a modified nominal group technique to develop recommendations for policy and program implications.

DISCUSSION AND IMPLICATIONS OF RESULTS

The 1987 Coordinated Discretionary Funds Program 2.1.D. allowed the State of Montana to develop and successfully complete a 22-month pilot statewide public education campaign designed to promote better mental health service delivery to Montana elderly, including off-reservation and on-reservation Indian elders.

The compilation of data regarding the use of community mental health centers by Montana elderly was productive. The analysis, including the further development of the "crosswalk," documented that only .009% of the 126,100 older adults are being served by the Community Mental Health Centers. The Indian Health Service, during the same period of analysis, served .025% of reservation Native American Indians 60 years of age or older. The elderly, though, represent 6% of the total caseload of the mental health centers and is consistent with the National Institute of Mental Health national average of 6% client utilization of mental health centers over 60 caseload. Although it could be argued that the older adults are undeserved based upon their representing 16.2% of Montana's population, the argument is based on the assumption that each age cohort has an equal percentage of mental health problems.

A 1989 study by the Montana Center of Gerontology, "Older Montanans: Their Characteristics, Problems and Need for Service," which was designed to identify the unmet needs of the older Montanan, found that .015% of the elderly are suffering from and or are being treated for mental health problems and that .033% of Montana elderly have had treatment or counseling for personal/family problems or for nervous/emotional problems in the past year. Ten percent of older Montanans have been depressed/very unhappy during the past few weeks and 9.1% checked that they have been lonely or remote from other people. Thus, based on the unmet needs study of 415 older Montanans, it is apparent that Montana's Community Mental Health Centers and Indian Health Service are not meeting all the needs of the elderly. Further inquiry into the underlying reasons is obviously necessary.

The high attendance by licensed mental health professionals at the four

one-day regional seminars reaffirms the growing awareness among mental health professionals that knowledge of the relationships between mental health and aging is critical and that further education and training in geriatrics and gerontology should be promoted and supported by public and private funds.

The two 28-minute videotapes produced by this project have been utilized in county and federal Indian reservation seminars and will be further utilized in future workshops, seminars, and conferences. Although the second videotape, "Network of Mental Health Services for Older Montanans," focuses on Montana, the first videotape, "Mental Health Problems of Older Adults," may be of interest to other State Units on Aging and Area Agencies on Aging.

Montana's 14 television stations, including one Public Broadcasting Station, were responsive and cooperated by airing the 12 30-60-second public service announcements. Thus, virtually every Montanan who watches television has had an opportunity to view the PSAs that were aired monthly over a one-year period of time.

The 12 newspaper articles prepared for the public awareness campaign will be distributed to Montana's 15 daily and 72 weekly newspapers. In addition, the articles will be distributed to 17 Title III aging newsletters. The printing of the articles will further impact the public's awareness regarding the mental health problems of the elderly.

The 70,000 brochures in the hands of the public identify some problems for which older adults seek help, the common services provided by community mental health centers, and where to go or call for help.

Over 1500 people attended the county and federal Indian reservation seminars. These individuals now have an understanding of the mental health problems of the elderly, the mental health system, and of the necessity of integrating the mental health system into the continuum of care for older Montanans, rather than as viewing the community mental health centers as a single service provider.

The Statewide Conference developed a number of recommendations that will be considered by the Governor of Montana and his Advisory Council on Aging. These recommendations are included in the "Montana Aging Policy Perspective: 1990" study and will be further discussed, considered, and developed for legislative action and implementation.

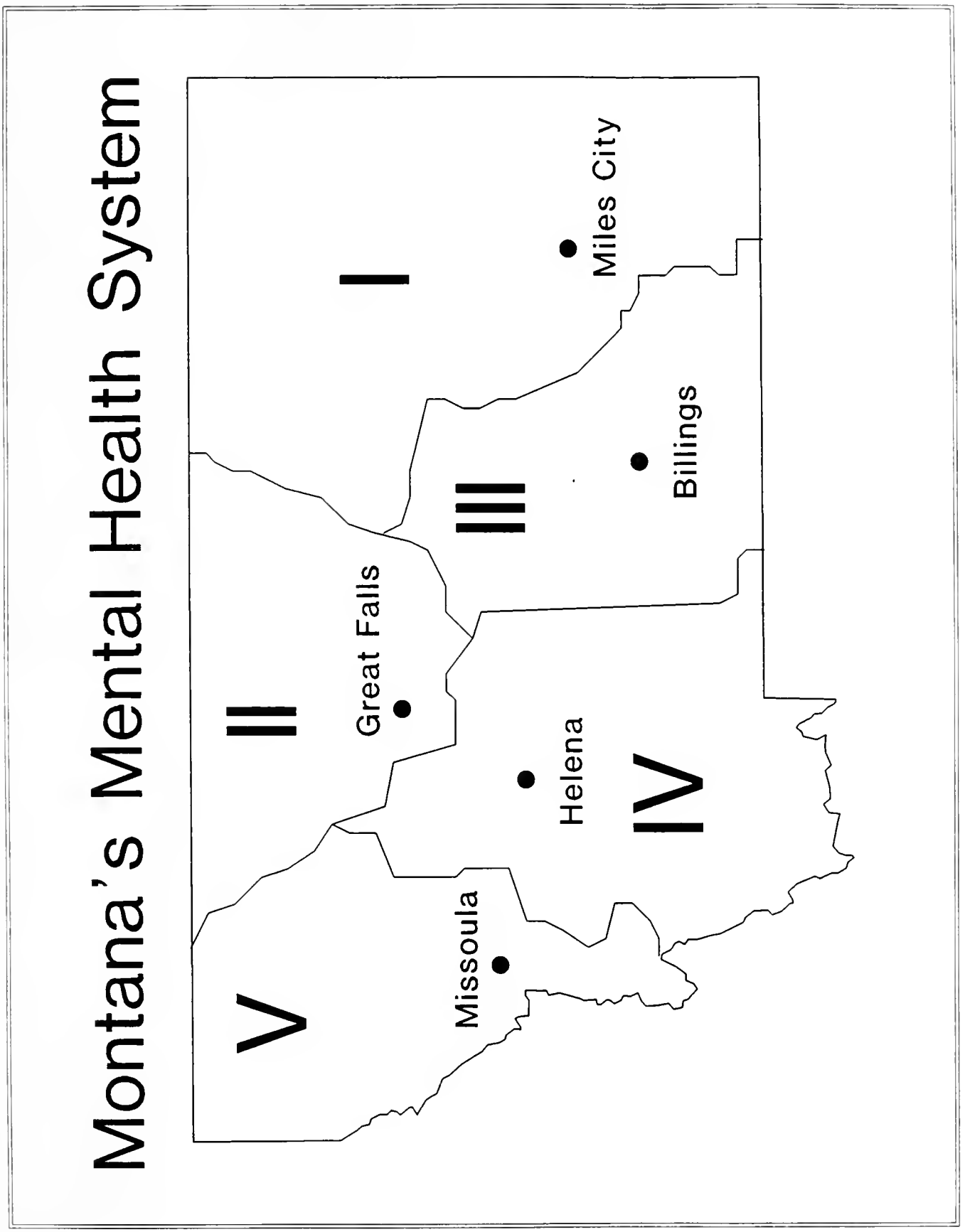
Finally, although one can not estimate accurately the number of Montanans who viewed the PSAs and will read the forthcoming newspaper articles, over 4000 Montanans were directly involved in and affected by discussing and learning about the mental health care problems of older adults.

SUMMARY

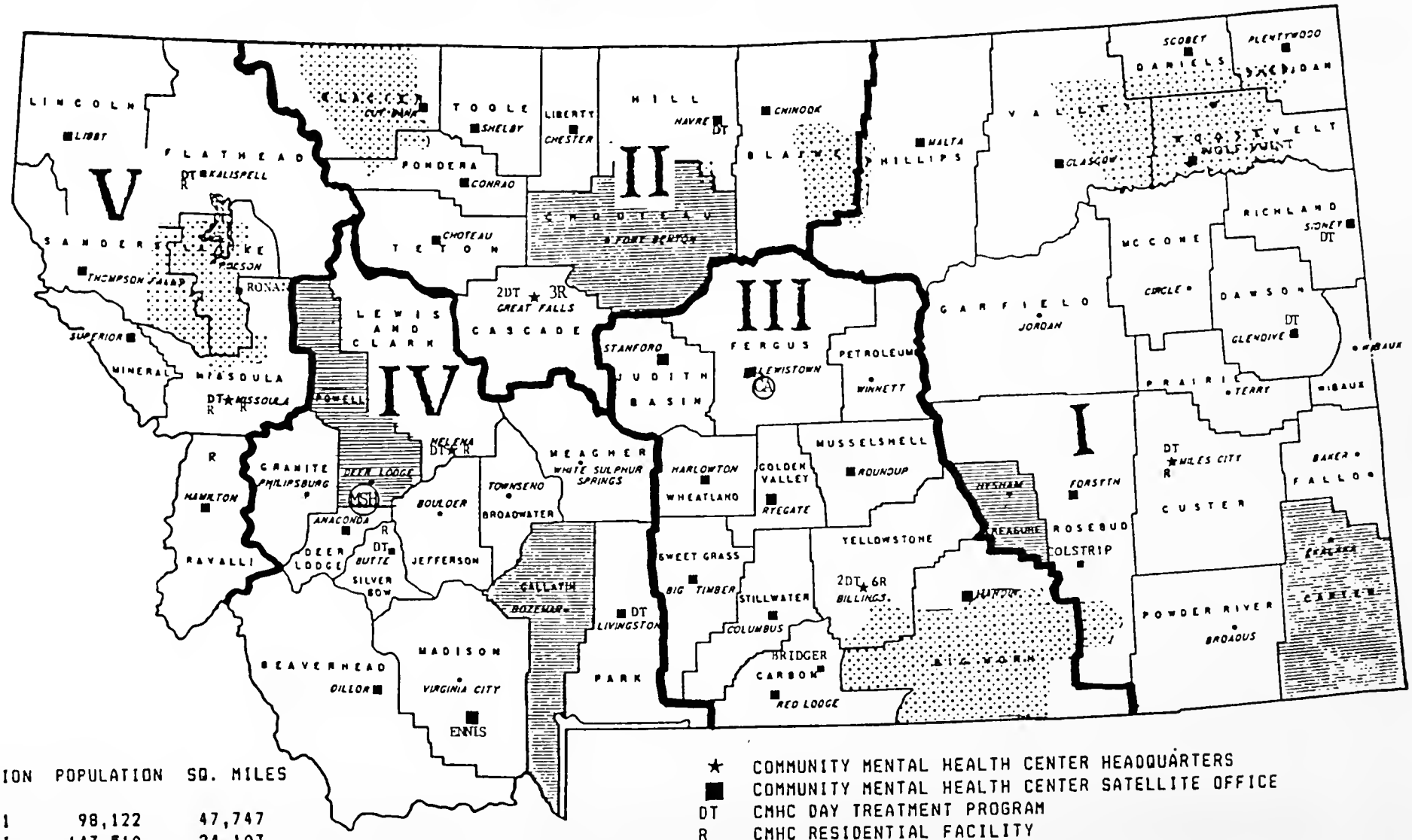
One of the most important challenges facing Montana's gerontological service providers is the provision of appropriate and effective care for elderly persons experiencing emotional or cognitive distress. While 10% of older Montanans have symptoms of emotional distress, only .015% are being treated by mental health professionals and only .009% of these are availing themselves of the Community Mental Health Centers. One of the reasons for this low incidence utilization of mental health professionals is that many Montana elderly are "rugged individualists," often isolated from mental health services, fearful, and are disinclined to use any public service that appears to them to be government charity, particularly from an agency that treats the mentally ill. Thus, this project was developed with the conviction that licensed mental health professionals would benefit by availing themselves of educational seminars on mental health and aging topics and issues; that the public, including eligible or troubled elderly, would benefit from seeing and reading about these mental health problems; that discussions in local communities would further the provision of an integrated system of services to the older adult; and that the elderly, their children, and service providers would recognize the symptoms of mental illness and effectively refer and more frequently access the Community Mental Health Centers and Indian Health Service.

FIGURES

Figure 1: Montana's Mental Health System



MONTANA'S MENTAL HEALTH SYSTEM



REGION	POPULATION	SQ. MILES
I	98,122	47,747
II	143,510	24,103
III	160,234	25,637
IV	185,191	28,753
V	199,633	19,152

★ COMMUNITY MENTAL HEALTH CENTER HEADQUARTERS
■ COMMUNITY MENTAL HEALTH CENTER SATELLITE OFFICE
DT CMHC DAY TREATMENT PROGRAM
R CMHC RESIDENTIAL FACILITY

(CA) CENTER FOR THE AGED @ LEWISTOWN

(MSH) MONTANA STATE HOSPITAL @ WARM SPRINGS

NON-PARTICIPATING COUNTIES
INDIAN RESERVATIONS

Figure 2: DSM Diagnostic Criteria Collapsed Into 32 Categories

DSM DIAGNOSTIC CRITERIA COLLAPSED INTO 32 CATEGORIES

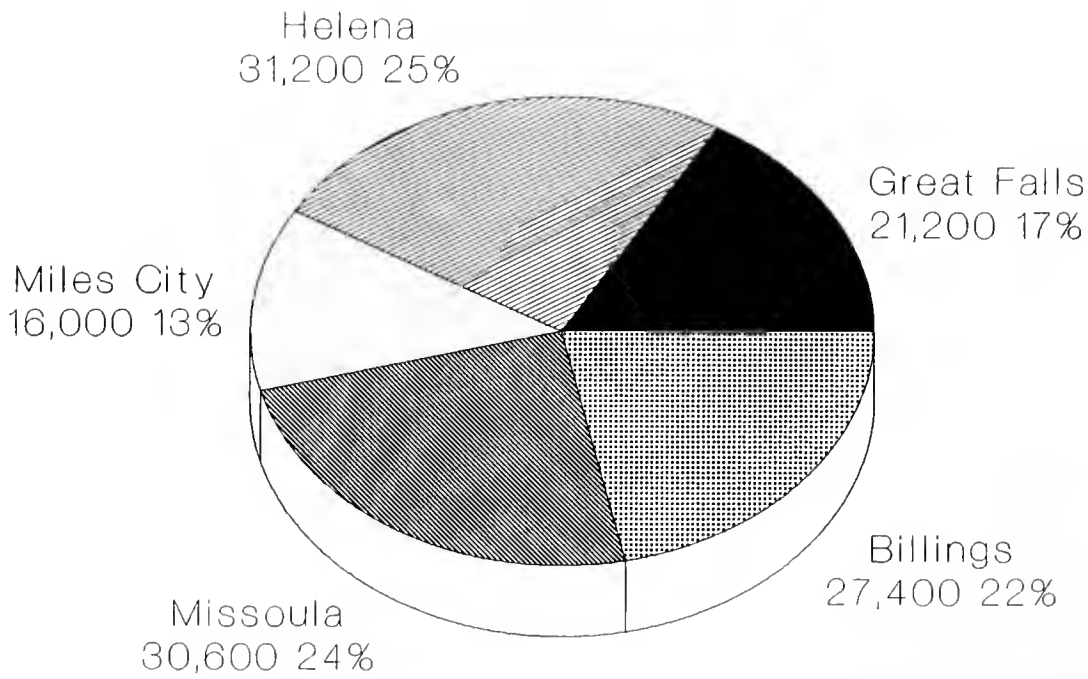
01 MENTAL RETARDATION
02 ATTENTION DEFICIT
03 CONDUCT
04 EATING, MOVEMENT & OTHER PHYSICAL MANIFESTATIONS
05 CHILDHOOD ANXIETY
06 AUTISM & PERVASIVE DEVELOPMENTAL
07 SPECIFIC DEVELOPMENTAL
08 OTHER CHILDHOOD DISORDERS
09 PRIMARY DEGENERATIVE DEMENTIA
10 MULTI-INFARCT DEMENTIA
11 SUBSTANCE (DRUG) RELATED DISORDERS
12 ALCOHOL ABUSE
13 ALCOHOL RELATED ORGANIC MENTAL DISORDERS
14 OTHER ORGANIC MENTAL DISORDERS
15 SCHIZOPHRENIC
16 SCHIZOPHRENIFORM
17 SCHIZOAFFECTIVE
18 PARANOID
19 OTHER PSYCHOTIC
20 BIPOLAR
21 MAJOR DEPRESSIVE
22 DYSTHYMIA
23 ANXIETY
24 SOMATOFORM
25 DISSOCIATIVE
26 SEXUAL
27 PERSONALITY AND OTHER IMPULSE
28 ADJUSTMENT
29 OTHER NONPSYCHOTIC MENTAL DISORDERS
30 SOCIAL CONDITIONS
31 NO MENTAL DISORDER
32 DIAGNOSIS DEFERRED

32 CATEGORIES COLLAPSED INTO 14 CATEGORIES. NUMBERS CORRESPOND TO ITEM IN THE 32 CATEGORY LIST.

01 MENTAL RETARDATION (1)
02 ALCOHOL RELATED (12, 13)
03 SUBSTANCE (DRUG) RELATED (11)
04 NON-ALCOHOLIC OR DRUG RELATED ORGANIC DISORDERS (9, 10, 14)
05 AFFECTIVE DISORDERS (20, 21, 22)
06 SCHIZOPHRENIA & RELATED DISORDERS (6, 15, 16, 17)
07 OTHER PSYCHOTIC (18, 19)
08 ANXIETY/SOMATOFORM/DISSOCIATIVE (23, 24, 25)
09 PERSONALITY/FACTITIOUS IMPULSE (27)
10 PRE-ADULT--ATTENTION/ANXIETY/CONDUCT DISORDERS (2, 3, 5)
11 OTHER NONPSYCHOTIC--ADULT & PRE-ADULT (4, 7, 8, 26, 28, 29)
12 SOCIAL CONDITIONS
13 NO MENTAL DISORDER (31)
14 DIAGNOSIS DEFERRED (32)

Montana's Older Adult Population

Total Older Adult Population: 126,100



Population By Region, And
Percentage Of Population By Region

Figure 3: Montana's Older Adult Population

Older Adult Demographics For Montana

1987 Montana Population	1987 Montana Older Adult Population 60 Years And Older	By Year 2000 U.S. Norm Will Be
777.6	126.1 (16.2%* of State)	14% >60 Years (Some Sources Estimate Higher)

*16.2% of Montana's population is presently 60 years of age and older, up 1% over 1980 Census figures of 15.2%

All population figures are in thousands of persons

All figures exclude Native Americans residing on reservations

Figure 4: Older Adult Demographics for Montana

Community Mental Health Center Service To Older Adults in Montana

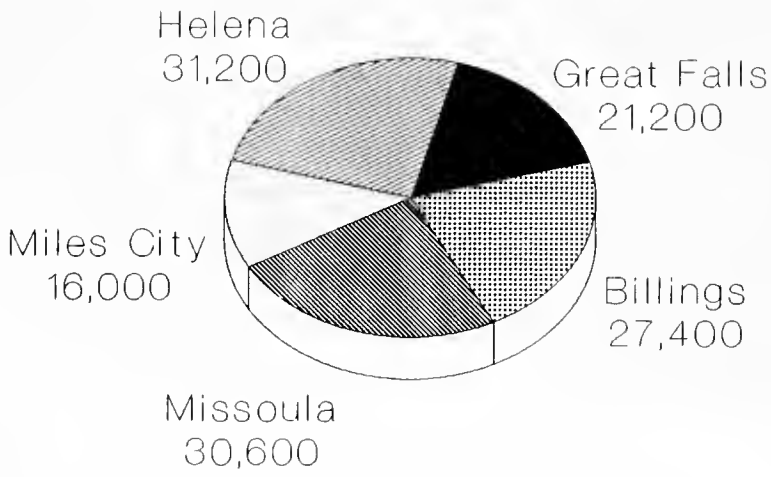
1987 Montana Population 60 Years And Older	Number of Montanans 60 Years And Older Served at Community Health Care Centers	Percent of Montana Older Adults Served in 1987 by Community Health Care Centers
126,100	970	<1 Percent

National norm "needs" estimates are that 15-25 percent of older adults suffer from some form of mental illness.

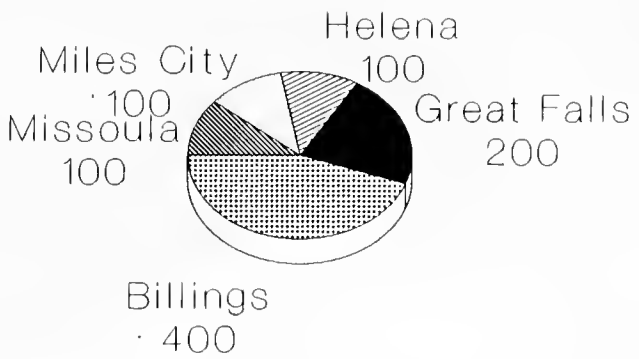
The role of private counseling and other private enterprises in serving older adults is unknown. There are 44 psychiatrists in Montana that serve our state.

Figure 5: Community Mental Health Center Services to Older Adults in Montana

Older Adult Out-Patients Served
By Community Mental Health Centers



Older Population By Region

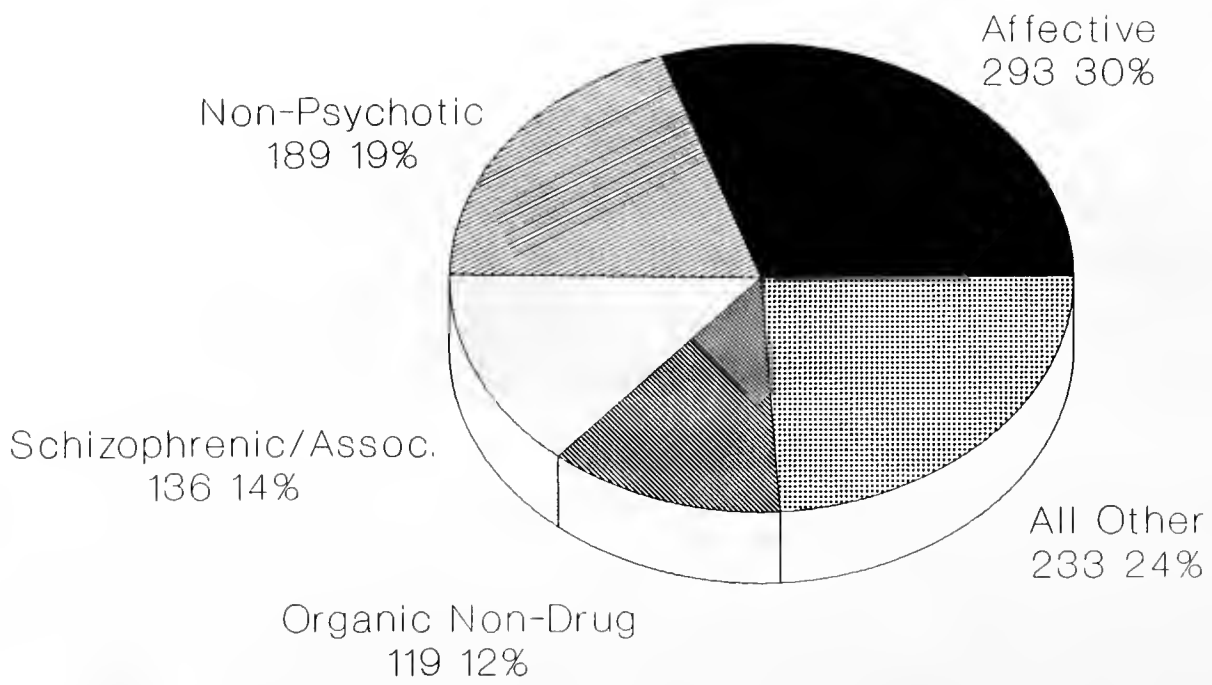


Number of Older Adult Out-Patients Served

Helena & Missoula Serve Less Than 1%, While Other Regions Serve About 1%

Figure 6: Older Adult Out-Patients Served by Community Mental Health Centers in Montana

"Big-Four" Mental Health Illnesses
Among Older Montanans

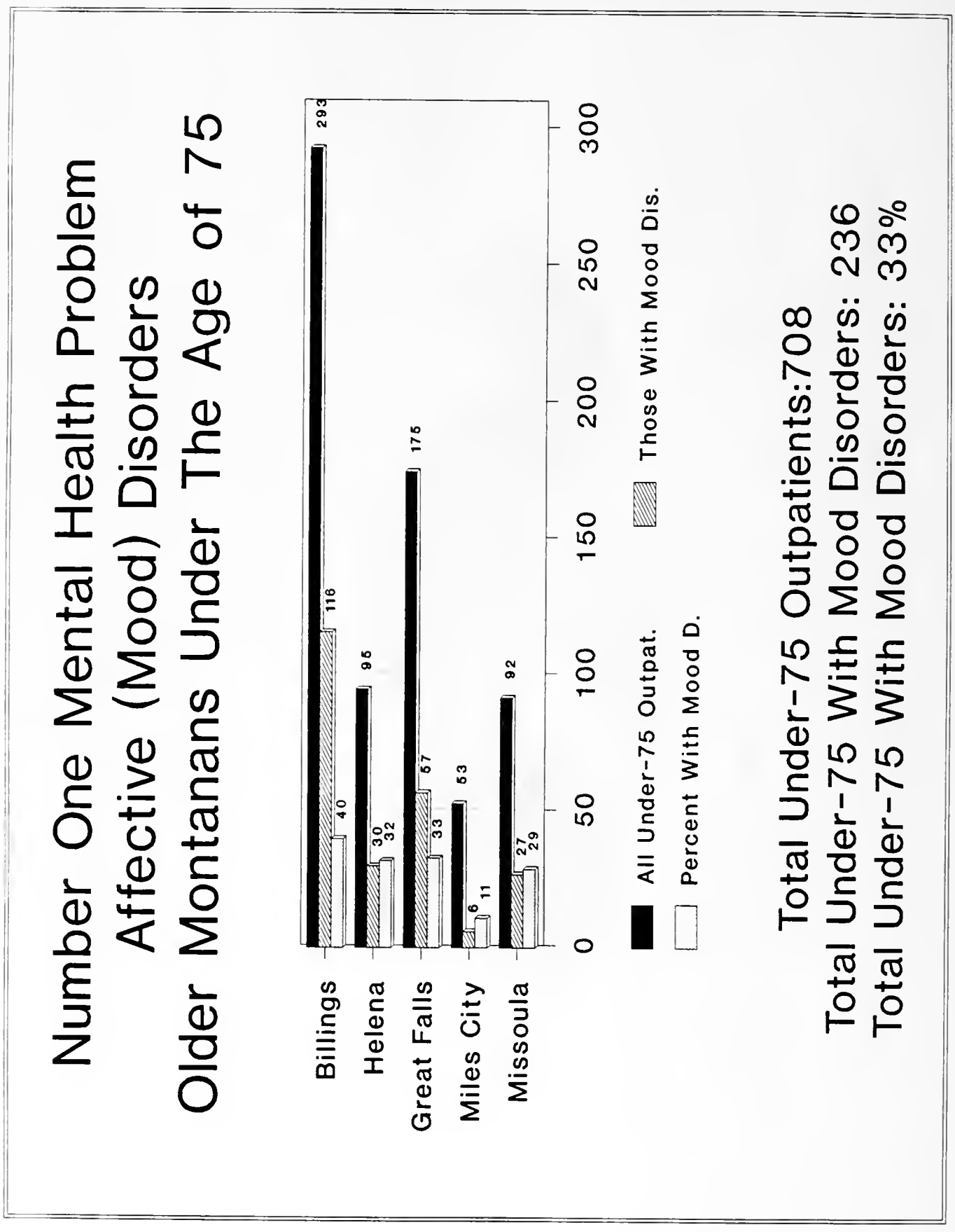


Total Montana Diagnoses: 970

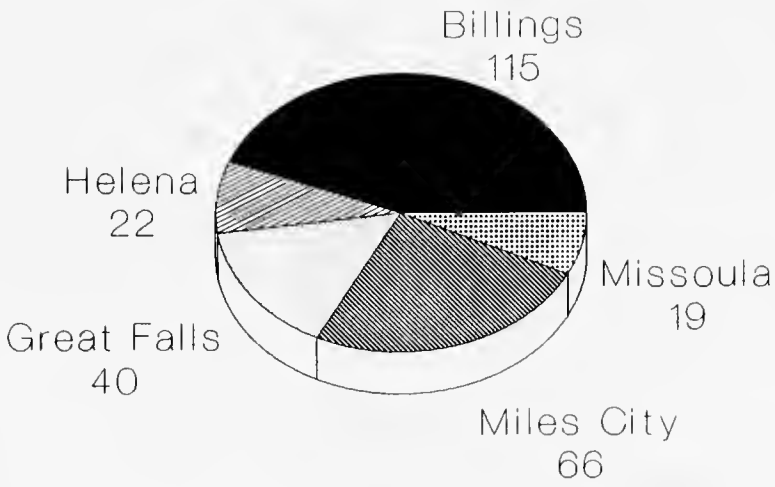
Figure 7: "Big Four" Mental Health Illnesses Among Older Montanans

Figure 8: Number One Mental Health Problem, Affective (Mood) Disorders, Older Montanans Under the Age of 75

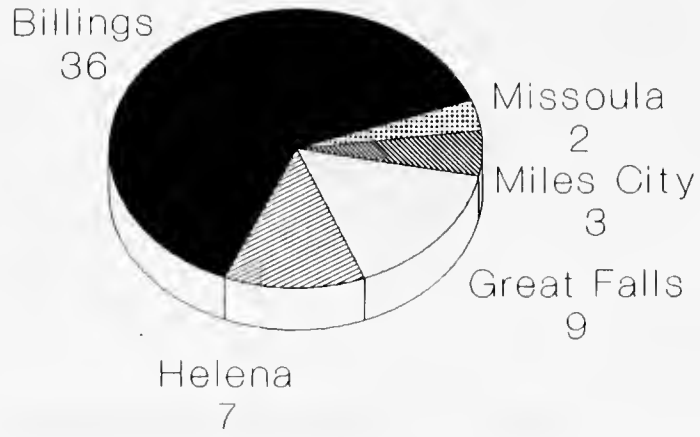
Figure 9: Number One Mental Health Problem, Affective (Mood) Disorders, Older Montanans Under the Age of 75



Number One Mental Health Problem
Affective (Mood) Disorders
Montanans 75 Years And Older



All 75 & Over
Outpatients By Region

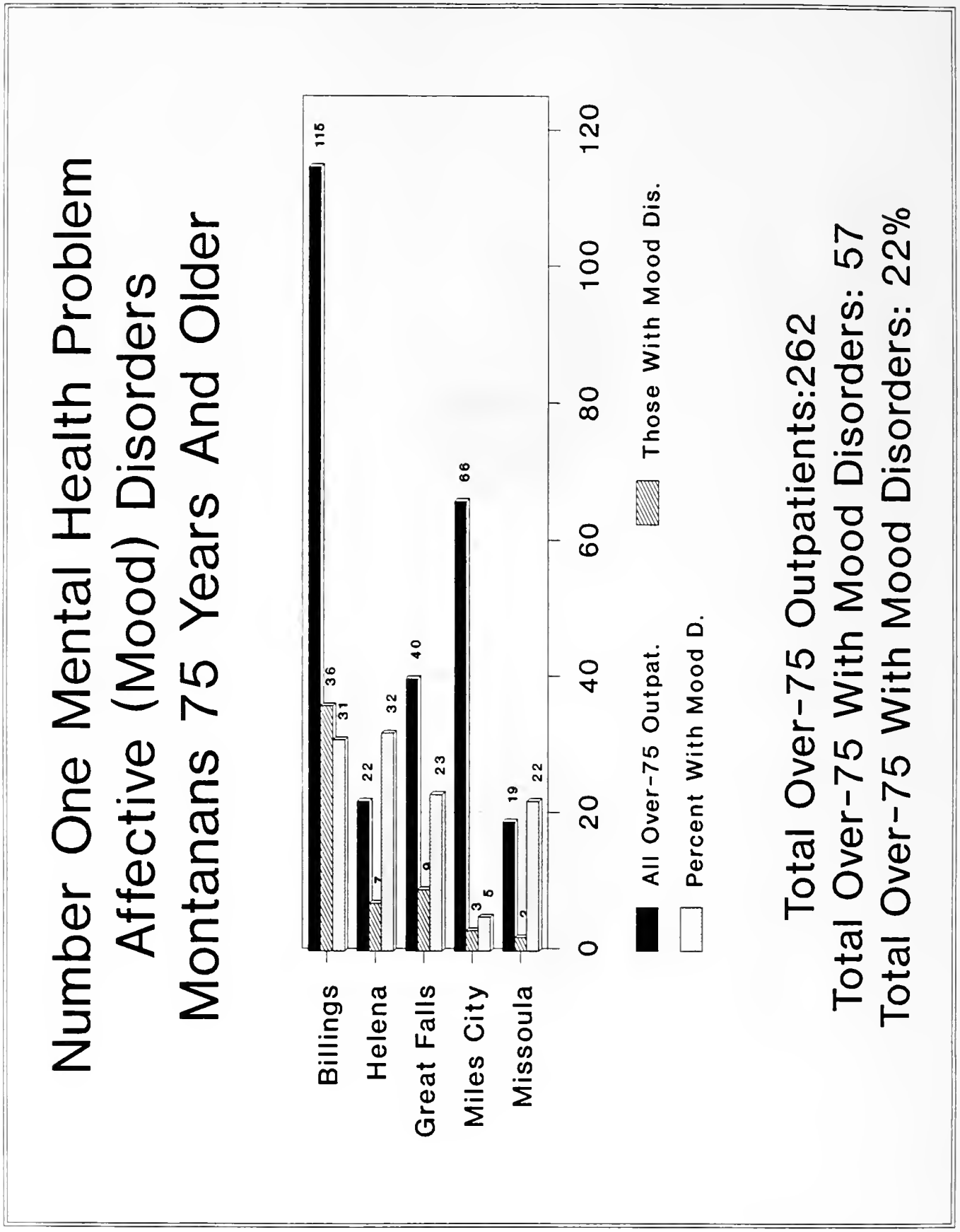


Those With
Mood Disorders

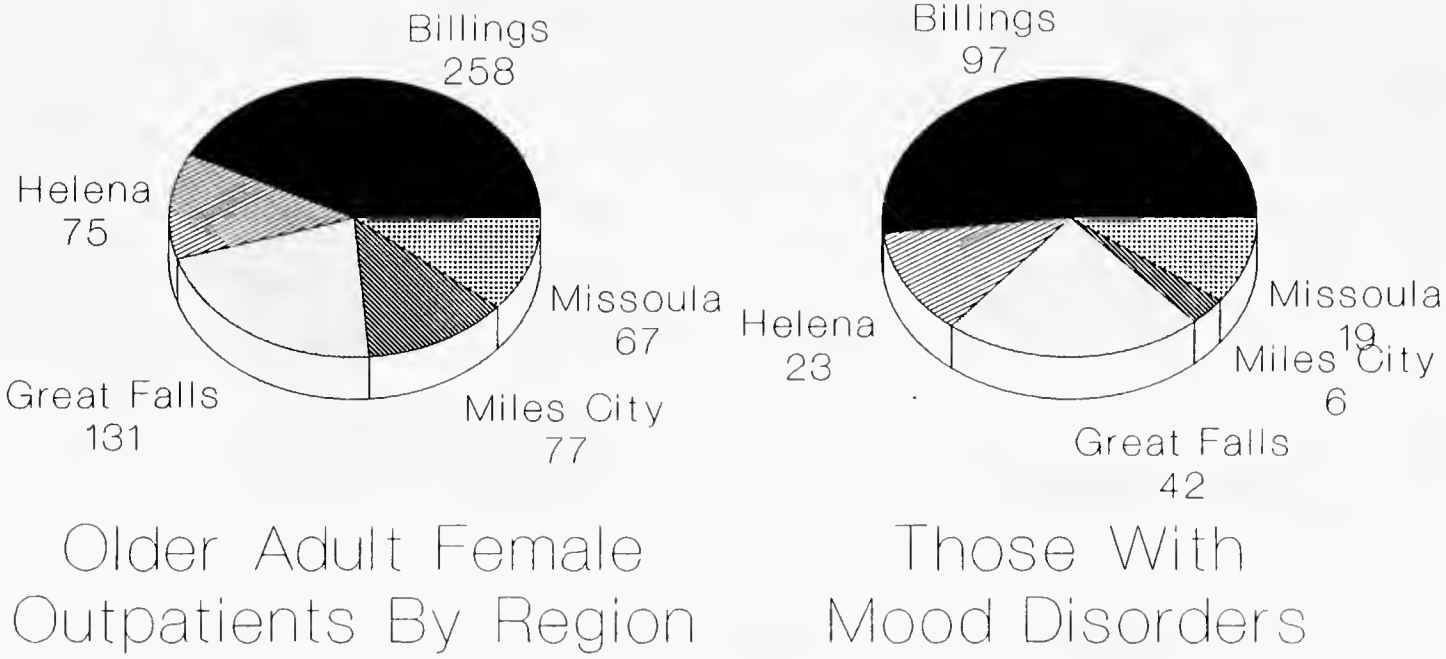
Total Over-75 Outpatients:262
Total Over-75 With Mood Disorders: 57
Total Over-75 With Mood Disorders: 22%

Figure 10: Number One Mental Health Problem, Affective (Mood) Disorders, Montanans 75 Years and Older

Figure 11: Number One Mental Health Problem, Affective (Mood) Disorders, Montanans 75 Years and Older



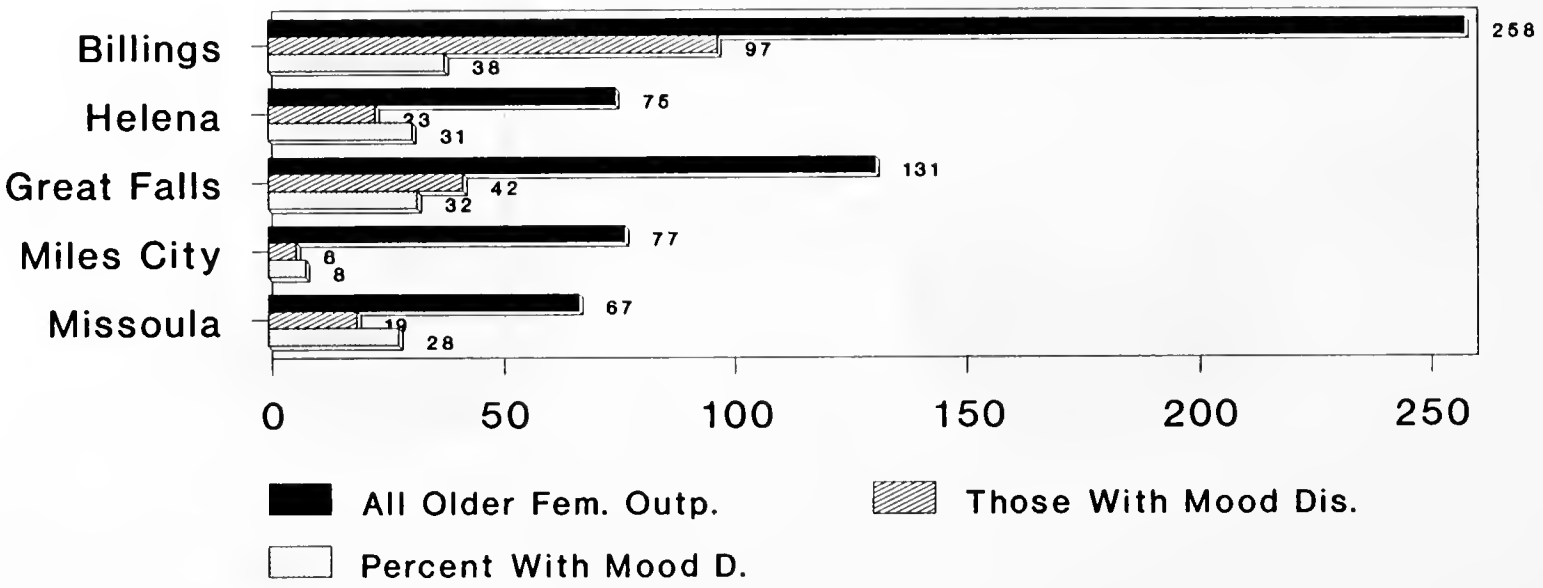
Number One Mental Health Problem
Affective (Mood) Disorders
Older Adult Females In Montana



Total Older Adult Female Outpatients:608
Older Females With Mood Disorders: 187
Older Females With Mood Disorders: 31%

Figure 12: Number One Mental Health Problem, Affective (Mood) Disorders, Older Adult Females in Montana

Number One Mental Health Problem
Affective (Mood) Disorders
Older Adult Females In Montana

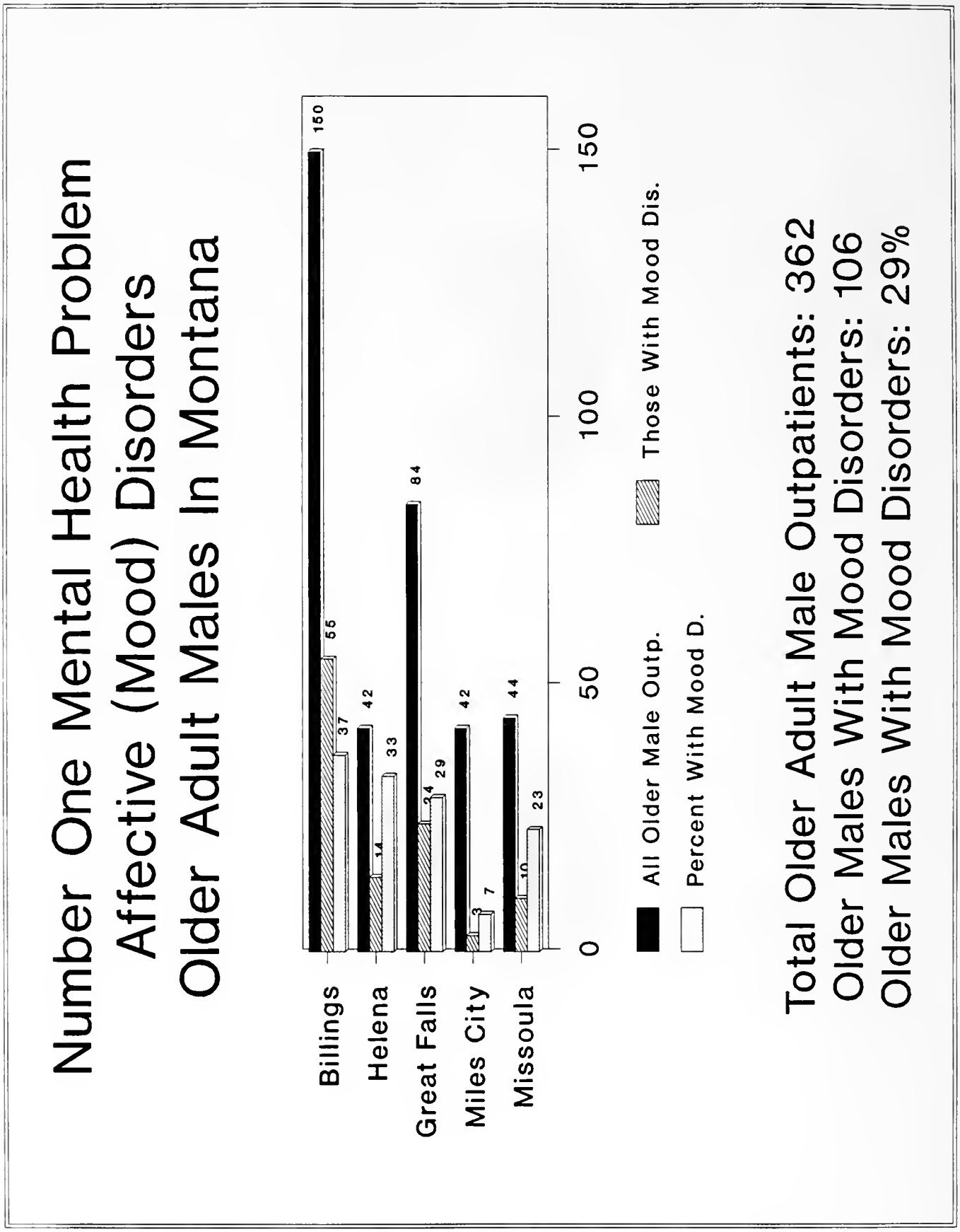


Total Older Adult Female Outpatients:608
Older Females With Mood Disorders: 187
Older Females With Mood Disorders: 31%

Figure 13: Number One Mental Health Problem, Affective (Mood) Disorders, Older Adult Females in Montana

Figure 14: Number One Mental Health Problem, Affective (Mood) Disorders, Older Adult Males in Montana

Figure 15: Number One Mental Health Problem, Affective (Mood) Disorders, Older Adult Males in Montana



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APPENDICES

Appendix A: Diagnostic Codes Crosswalk and Categories

THIRTY-TWO DIAGNOSTIC CATEGORIES	DSM-III DIAGNOSIS CODE	DSM-III-R DIAGNOSIS CODE	ICD-9-CM DIAGNOSIS CODE
01	319.01	319.00	319
01	318.00	319.00	318.0
01	318.20	318.20	318.2
01	318.11	318.10	318.1
01	317.01	317.00	317
01	318.10	318.10	318.1
01	319.00	319.00	319
01	318.21	318.20	318.2
01	318.01	318.00	318
01	317.00	317.00	317
02	314.01	314.01	314.01
02	314.00	314.00	314.00
02	314.80	314.01	314.8
03	NONE	312.20	NONE
03	312.00	312.00	312.00
03	312.90	312.90	312.9
03	312.21	NONE	312.21
03	312.10	NONE	312.10
03	312.23	NONE	312.23
04	307.23	307.23	307.23
04	307.30	307.30	307.3
04	NONE	307.46	NONE
04	307.10	307.10	307.1
04	307.50	307.50	307.50
04	307.00	307.00	307.0
04	307.20	307.20	307.20
04	NONE	307.45	NONE
04	NONE	307.42	NONE
04	307.52	307.52	307.52
04	307.60	307.60	307.6
04	NONE	307.47	NONE
04	307.49	NONE	307.46
04	307.51	307.51	307.51
04	307.53	307.53	307.53
04	307.47	307.44	307.46
04	307.21	307.21	307.21
04	307.70	307.70	307.7
04	307.22	307.22	307.22
04	NONE	307.40	NONE
05	313.21	313.21	313.21
05	313.00	313.00	313.0
05	309.21	309.21	309.21
06	299.80	299.80	299.80
06	299.01	299.00	299.01
06	299.81	299.80	299.81
06	299.00	299.00	299.00

THIRTY-TWO DIAGNOSTIC CATEGORIES	DSM-III DIAGNOSIS CODE	DSM-III-R DIAGNOSIS CODE	ICD-9-CM DIAGNOSIS CODE
06	299.91	299.00	299.91
06	299.90	299.00	299.90
07	315.50	315.90	315.5
07	315.39	315.39	315.39
07	315.90	315.90	315.9
07	315.00	315.00	315.00
07	NONE	315.80	NONE
07	NONE	315.40	NONE
07	315.10	315.10	315.1
07	315.31	315.131	315.31
08	313.89	313.89	313.89
08	313.82	313.82	313.82
08	313.81	313.81	313.81
08	313.22	NONE	313.22
08	313.23	313.23	313.23
09	290.21	290.21	290.21
09	290.13	290.13	290.13
09	290.12	290.12	290.12
09	290.10	290.10	290.10
09	290.00	290.00	290.0
09	290.20	290.20	290.20
09	290.30	290.30	290.3
09	290.11	290.11	290.11
10	290.41	290.21	290.41
10	290.40	290.40	290.40
10	290.43	290.43	290.43
10	290.42	290.42	290.42
11	305.31	305.30	305.31
11	304.90	304.90	304.90
11	305.33	305.30	305.33
11	305.23	305.20	305.23
11	327.32	292.81	292.81
11	305.40	305.40	305.40
11	305.21	305.20	305.21
11	305.42	305.40	305.42
11	305.50	305.50	305.50
11	305.22	305.20	305.22
11	NONE	304.20	NONE
11	304.10	304.10	304.10
11	327.35	292.11	292.11
11	305.31	305.50	305.51
11	304.13	304.10	304.13
11	327.92	292.81	292.81
11	328.43	305.93	305.93
11	327.90	305.90	305.90
11	304.91	304.00	304.01
11	327.42	292.81	292.81
11	327.96	292.12	292.12
11	304.00	304.00	304.00

THIRTY-TWO DIAGNOSTIC CATEGORIES	DSM-III DIAGNOSIS CODE	DSM-III-R DIAGNOSIS CODE	ICD-9-CM DIAGNOSIS CODE
11	304.02	304.00	304.02
11	305.92	305.90	305.92
11	327.94	292.83	292.83
11	304.30	304.30	304.30
11	327.31	292.00	292.0
11	304.33	304.30	304.33
11	304.41	304.40	304. 41
11	304.43	304.40	304.43
11	305.43	305.40	305.43
11	328.42	305.92	305.92
11	304.70	NONE	304.70
11	304.72	NONE	304.72
11	327.80	305.90	305.90
11	327.95	292.11	292.11
11	327.00	305.40	305.40
11	327.93	292.82	292.82
11	304.31	304.30	304.31
11	305.93	305.90	305.93
11	305.90	305.90	305.90
11	327.57	292.84	292.84
11	292.90	292.90	292.90
11	327.11	292.00	292.00
11	327.30	305.70	305.70
11	304.12	304.10	304.12
11	304.03	304.00	304.03
11	292.89	292.89	292.89
11	292.84	292.84	292.84
11	327.99	292.90	292.90
11	327.49	292.90	292.90
11	292.82	292.82	292.82
11	327.56	305.30	305.30
11	292.83	292.83	292.83
11	304.40	304.40	304.40
11	304.60	304.60	304.60
11	328.40	305.90	305.90
11	NONE	304.50	NONE
11	327.01	292.00	292.0
11	292.12	292.12	292.12
11	304.61	304.60	304.61
11	292.11	292.11	292.11
11	305.53	305.50	305.53
11	292.00	292.00	292.0
11	327.04	292.83	292.83
11	327.02	292.00	292.0
11	305.11	305.10	305.11
11	304.42	304.40	304.42
11	304.73	NONE	304.73
11	327.98	292.89	292.89
11	327.65	292.11	292.11

THIRTY-TWO DIAGNOSTIC CATEGORIES	DSM-III DIAGNOSIS CODE	DSM-III-R DIAGNOSIS CODE	ICD-9-CM DIAGNOSIS CODE
11	304.71	NONE	304.71
11	327.10	305.50	305.50
11	327.55	292.11	292.11
11	304.82	NONE	304.82
11	327.20	305.60	305.60
11	304.81	NONE	304.81
11	304.62	304.60	304.62
11	327.60	305.20	305.20
11	304.80	NONE	304.80
11	305.91	305.90	305.91
11	305.73	305.70	305.73
11	304.63	304.60	304.63
11	292.81	292.81	292.81
11	305.71	305.70	305.71
11	327.71	292.00	292.0
11	304.92	304.90	304.92
11	305.61	305.60	305.61
11	305.13	305.10	305.13
11	304.91	304.90	304.91
11	304.11	304.10	304.11
11	305.60	305.60	305.60
11	305.52	305.50	305.52
11	305.41	305.40	305.41
11	304.93	304.90	304.93
11	328.41	305.91	305.91
11	305.70	305.70	305.70
11	327.97	292.84	292.84
11	304.83	NONE	304.83
11	305.30	305.30	305.30
11	305.72	305.70	305.72
11	305.63	305.60	305.63
11	305.20	305.20	305.20
11	305.12	305.10	305.12
11	305.62	305.60	305.62
11	327.40	305.90	305.90
11	327.91	292.00	292.0
11	305.10	305.10	305.10
11	305.32	305.30	305.32
11	304.32	304.30	304.32
12	305.00	305.00	305.00
12	303.93	303.90	303.93
12	303.92	303.90	303.92
12	303.91	303.90	303.91
12	303.90	303.90	303.90
12	305.01	305.00	305.01
12	305.03	305.00	305.03
12	305.02	305.00	305.02
13	291.00	291.00	291.0
13	303.00	303.00	303.00

THIRTY-TWO DIAGNOSTIC CATEGORIES	DSM-III DIAGNOSIS CODE	DSM-III-R DIAGNOSIS CODE	ICD-9-CM DIAGNOSIS CODE
13	291.80	291.80	291.8
13	291.40	291.40	291.4
13	291.30	291.30	291.3
13	291.23	291.20	291.2
13	291.22	291.20	291.2
13	291.21	291.20	291.2
13	291.20	291.20	291.2
13	291.10	291.10	291.1
14	294.80	294.80	294.80
14	294.10	294.10	294.1
14	294.00	294.00	294.0
14	310.10	310.10	310.1
14	293.81	293.81	293.81
14	293.00	293.00	293.0
14	293.83	293.83	293.83
14	NONE	311.00	NONE
14	293.82	293.82	293.82
15	295.14	295.14	295.14
15	295.13	295.13	295.13
15	295.12	295.12	295.12
15	295.11	295.11	295.11
15	295.10	295.10	295.10
15	295.95	295.95	295.95
15	295.94	295.94	295.94
15	295.93	295.93	295.93
15	295.92	295.92	295.92
15	295.91	295.91	295.91
15	295.90	295.90	295.90
15	NONE	295.64	NONE
15	295.62	295.62	295.62
15	NONE	295.63	NONE
15	295.61	295.61	295.61
15	295.60	295.60	295.60
15	295.35	NONE	295.35
15	295.34	295.34	295.34
15	295.33	295.33	295.33
15	295.32	295.32	295.32
15	295.31	295.31	295.31
15	295.30	295.30	295.30
15	295.25	NONE	295.25
15	295.24	295.24	295.24
15	295.23	295.23	295.23
15	295.22	295.22	295.22
15	295.21	295.21	295.21
15	295.20	295.20	295.20
15	295.15	NONE	295.15
16	295.40	295.40	295.40
17	295.70	295.70	295.70
18	293.80	301.00	298.3

THIRTY-TWO DIAGNOSTIC CATEGORIES	DSM-III DIAGNOSIS CODE	DSM-III-R DIAGNOSIS CODE	ICD-9-CM DIAGNOSIS CODE
18	297.30	301.00	297.9
18	297.30	297.30	297.30
18	297.10	297.10	297.1
19	298.90	298.90	298.9
19	298.80	298.80	298.80
20	296.57	NONE	296.54
20	296.56	296.56	NONE
20	296.56	296.56	296.56
20	296.54	296.54	296.54
20	296.53	296.53	296.53
20	NONE	296.52	NONE
20	296.52	296.51	296.52
20	296.50	296.50	296.50
20	296.47	NONE	296.44
20	NONE	296.46	NONE
20	296.46	296.45	296.46
20	296.44	296.44	296.44
20	NONE	296.43	NONE
20	296.42	296.42	296.42
20	NONE	296.41	NONE
20	296.40	296.40	296.40
20	301.13	301.13	301.13
20	296.70	296.70	296.7
20	296.67	NONE	296.64
20	296.66	296.66	296.66
20	NONE	296.65	NONE
20	296.64	296.64	296.64
20	NONE	296.63	NONE
20	296.62	296.62	296.62
20	296.60	296.60	296.60
21	296.37	NONE	296.34
21	296.36	296.36	296.36
21	296.34	296.34	296.34
21	296.33	296.33	296.33
21	296.32	296.32	296.32
21	NONE	296.31	NONE
21	296.30	296.30	296.30
21	296.27	NONE	296.24
21	296.26	296.26	296.26
21	NONE	296.25	NONE
21	296.24	296.24	296.24
21	296.23	NONE	296.23
21	296.22	296.22	296.22
21	NONE	296.21	NONE
21	296.20	296.20	296.20
21	NONE	296.35	NONE
21	296.82	311.00	296.82
22	300.40	300.40	300.40
23	300.30	300.30	300.3

THIRTY-TWO DIAGNOSTIC CATEGORIES	DSM-III DIAGNOSIS CODE	DSM-III-R DIAGNOSIS CODE	ICD-9-CM DIAGNOSIS CODE
23	NONE	309.82	NONE
23	309.81	309.89	309.81
23	300.29	300.29	300.29
23	300.23	300.23	300.23
23	300.22	300.22	300.22
23	300.21	300.21	300.21
23	308.30	309.89	308.3
23	300.02	300.02	300.02
23	300.01	300.01	300.01
23	300.00	300.00	300.00
24	300.81	300.81	300.81
24	300.71	300.70	300.7
24	300.70	300.70	300.7
24	NONE	309.70	NONE
24	307.80	307.80	307.80
24	300.11	300.11	300.11
25	300.60	300.60	300.6
25	300.15	300.15	300.15
25	300.14	300.14	300.14
25	300.13	300.13	300.13
25	300.12	300.12	300.12
26	302.90	302.90	302.9
26	302.89	302.89	302.89
26	302.85	302.85	302.85
26	302.84	302.84	302.84
26	302.83	302.83	302.83
26	302.82	302.82	302.82
26	302.81	302.81	302.81
26	NONE	302.79	NONE
26	302.76	302.76	302.76
26	302.75	302.75	302.75
26	302.74	302.74	302.74
26	302.73	302.73	302.73
26	302.72	302.72	302.72
26	302.71	302.71	302.71
26	302.70	302.70	302.70
26	302.60	302.60	302.6
26	302.53	302.50	302.53
26	302.52	302.50	302.52
26	302.51	302.50	302.51
26	302.50	302.50	302.50
26	302.40	302.40	302.4
26	302.30	302.30	302.3
26	302.20	302.20	302.2
26	302.10	NONE	302.1
26	302.00	NONE	302.0
26	306.51	306.51	306.51
27	301.89	301.90	301.89
27	301.84	301.84	301.84

THIRTY-TWO DIAGNOSTIC CATEGORIES	DSM-III DIAGNOSIS CODE	DSM-III-R DIAGNOSIS CODE	ICD-9-CM DIAGNOSIS CODE
27	301.83	301.83	301.83
27	301.82	301.82	301.82
27	301.81	301.81	301.81
27	301.70	301.70	301.7
27	301.60	301.60	301.6
27	301.51	301.51	301.51
27	301.50	301.50	301.50
27	301.40	301.40	301.4
27	301.22	301.22	301.22
27	301.20	301.20	301.20
27	301.00	301.00	301.0
27	312.39	312.39	312.39
27	312.35	312.34	312.35
27	312.34	312.34	312.34
27	312.33	312.33	312.33
27	312.32	312.32	312.32
27	312.31	312.31	312.31
27	300.19	300.19	300.19
27	300.16	300.16	300.16
28	309.90	309.90	309.9
28	NONE	309.89	NONE
28	309.83	309.83	309.83
28	309.40	309.40	309.4
28	309.30	309.30	309.30
28	309.28	309.28	309.28
28	309.24	309.24	309.24
28	309.23	309.23	309.23
28	309.00	309.00	309.0
29	316.00	316.00	316
29	300.90	300.90	300.9
30	V65.20	V65.20	V65.2
30	V62.89	V62.89	V62.89
30	V61.20	V61.20	V61.20
30	V61.10	V61.10	V61.1
30	V62.88	V62.89	V62.89
30	V62.82	V62.82	V62.82
30	V62.81	V62.81	V62.81
30	V62.30	V62.30	V62.3
30	V15.81	V15.81	V15.81
30	V62.20	V62.20	V62.2
30	V71.02	V71.02	V71.02
30	V71.01	V71.01	V71.01
30	V61.80	V61.80	V61.80
31	V71.09	V71.09	V71.09
32	NONE	799.90	NONE
32	799.90	780.54	799.9
32	NONE	780.50	NONE

Appendix B: Definition of Diagnostic Categories

1. Mental Retardation

The essential feature of this disorder is that the predominant disturbance is in the acquisition of cognitive, language, motor, or social skills. The disturbance involves a general delay in a specific area of skill acquisition or multiple areas in which there are qualitative distortions of normal development are evident. Additional features of this disorder are: (1) significantly subaverage general intellectual functioning, accompanied by (2) significant deficits or impairments in adaptive functioning, with (3) onset before the age of 18. The diagnosis is made regardless of whether or not there is coexisting physical or other mental disorder.

2. Alcohol Related

This diagnostic category deals with symptoms and maladaptive behavioral changes associated with the more or less regular use of alcohol. Examples include continued use of alcohol despite the presence of a persistent or recurrent social, occupational, psychological, or physical problem that the person knows may be exacerbated by that use and the development of serious withdrawal symptoms following cessation of or reduction in use of alcohol. These conditions are here conceptualized as mental disorders, and are therefore to be distinguished from nonpathological alcohol use, such as the moderate imbibing of alcohol. Essential features of this disorder include:

A. Alcohol Dependence. A cluster of cognitive, behavioral, and physiologic symptoms that indicate the person has impaired control of alcohol use and continues use of alcohol despite adverse consequences. The symptoms of the dependence syndrome include, but are not limited to, the physiologic symptoms of tolerance and withdrawal.

B. Alcohol Abuse. A category for noting maladaptive patterns of use is indicated by either (1) continued use of alcohol despite knowledge of having a persistent or recurrent social, occupational, psychological, or physical problem that is caused or exacerbated by use of alcohol or (2) recurrent use of alcohol in situations when use is physically hazardous (e.g., driving while intoxicated). The diagnosis is made only if some symptoms of the abuse have persisted for at least one month or have occurred repeatedly over a longer period of time.

C. Alcohol-Related Organic Mental Disorders. This section includes Organic Mental Disorders attributed to the ingestion of alcohol. Included within this cluster are:

(1) alcohol intoxication
(2) uncomplicated alcohol withdrawal
(3) alcohol withdrawal with delirium
(4) alcohol hallucinosis
(5) alcohol amnesia
(6) dementia associated with alcoholism

3. Substance (Drug) Related

Criteria for this category are the same for the category "Alcohol Related," number two above, except that substances in this category exclude alcohol. Substances in this category include but are not limited to: amphetamine or similarly acting sympathomimetics; cannabis; cocaine; hallucinogens; inhalants; opioids; phencyclidine (PCP) or similarly acting arylcyclohexylamines; and sedatives, hypnotics, or anxiolytics.

4. Non-Alcoholic or Non-Drug Related Organic Disorders

The essential feature of all of these disorders is a psychological or behavioral abnormality associated with transient or permanent dysfunction of the brain. Organic Mental Disorders are diagnosed (1) by recognizing the presence of one of the Organic Mental Syndromes, as listed below, and (2) by demonstrating, by means of the history, physical examination, or laboratory tests, the presence of a specific organic factor (or factors) judged to be etiologically related to the abnormal mental state. Organic Mental Disorders are a heterogeneous group; therefore, no single description can characterize them all. The differences in clinical presentation reflect differences in the localization, mode of onset, progression, duration, and nature of the underlying pathophysiologic process. Excluded are organic disorders caused by alcohol or other drugs.

The organic factor responsible for an Organic Mental Disorder may be a primary disease of the brain or a systemic illness that secondarily affects the brain. Conditions included are:

(1) dementia syndrome (primary and multi-farct)
(2) amnestic syndrome
(3) delusional syndrome
(4) organic hallucinosis
(5) mood syndrome due to organic condition
(6) anxiety syndrome due to organic condition
(7) personality syndrome due to organic condition

5. Affective Disorders

The essential features of this group of disorders are disturbance of mood, accompanied by a full or partial Manic or Depressive Syndrome, that is not due to any other physical or mental disorder. Mood refers to a prolonged emotion that colors the whole psychic life. It generally involves either depression or elation. A Manic Episode is a distinct period during which the predominant mood is either elevated, expansive, or irritable, and associated symptoms of the Manic Syndrome are associated. The disturbance is sufficiently severe to cause marked impairment in occupational functioning or in usual social activities or relationships with others, or to require hospitalization to prevent harm to self or others. The associated symptoms include inflated self esteem or grandiosity (which may be delusional), decreased need for sleep, pressure of speech, flight of ideas, distractibility, increased involvement in goal-directed activity, psychomotor agitation, and excessive involvement in pleasurable activities which have a high potential for painful consequences that the person often does not recognize. The diagnosis is made only if it cannot be established that an organic factor initiated and maintained the disturbance. In addition, the diagnosis is not made if the disturbance is superimposed on Schizophr-

enia, Schizophreniform Disorder, Delusional Disorder, or Psychotic Disorder (not otherwise specified), or if a Major Depressive Episode is either depressed mood or loss of interest or pleasure in all, or almost all, activities and associated symptoms, for a period of at least two weeks. The symptoms represent a change from previous functioning and are relatively persistent, that is, they occur for most of the day, nearly every day, during at least a two-week period. The associated symptoms include appetite disturbance, change in weight, sleep disturbance, psychomotor agitation or retardation, decreased energy, feelings of worthlessness or excessive or inappropriate guilt, difficulty thinking or concentrating, and recurrent thoughts of death, or suicidal ideation or attempts. The diagnosis is made only if it cannot be established that an organic factor initiated and maintained the disturbance and the disturbance is not the normal reaction to the loss of a loved one (Uncomplicated Bereavement).

6. Schizophrenia and Related Disorders

The essential features of this disorder are the presence of characteristic psychotic symptoms. At some phase of the illness, Schizophrenia always involves delusions, hallucinations, or certain characteristic disturbances in the form of thought. The diagnosis is made only when it cannot be established that an organic factor initiated and maintained the disturbance. People who develop a major depressive or manic syndrome for an extended period relative to the duration of the disturbance are not classified as having Schizophrenia, but rather as having either a Mood or Schizoaffective Disorder. Included in this category are:

(1) autism and pervasive developmental disorders
(2) schizophrenic disorders
(3) schizophreniform disorders
(4) schizoaffective disorders

7. Other Psychotic Disorders

This class is for psychotic disorders that cannot be classified as either an Organic Mental Disorder, Schizophrenia, Delusional Disorder, or a Mood Disorder with Psychotic Features. There are three specific categories: Brief Reactive Psychosis, Induced Psychotic Disorder, and a residual category, Psychotic Disorder (not otherwise specified).

8. Anxiety/Somatoform/Dissociative

A. Anxiety: the characteristic features of this group of disorders are symptoms of anxiety and avoidance behavior. Although Post-traumatic Stress is included, the predominant symptom is the reexperiencing of a trauma, not anxiety or avoidance behavior.

B. Somatoform: the essential features of this group are physical symptoms suggesting physical disorder (hence, Somatoform) for which there are no demonstrable organic findings or known physiologic mechanisms, and for which there is positive factors or conflicts. The symptom production in Somatoform Disorders is not intentional, i.e., the person does not experience the sense of controlling symptom production. Although the symptoms of Somatoform Disorders are "physical," the specific pathophysiologic

processes involved are not demonstrable or understandable by existing laboratory procedures and are conceptualized most clearly by means of psychological constructs. For that reason, these are classified as mental disorders.

C. Dissociative: the essential feature of these disorders is a disturbance or alteration in the normally integrative functions of identity, memory, or consciousness. The disturbance or alteration may be sudden or gradual, and transient or chronic. If it occurs primarily in identity, the person's customary identity is temporarily forgotten, and a new identity may be assumed or imposed, or the customary feeling of one's own reality is lost and is replaced by a feeling of unreality. If the disturbance occurs primarily in memory, important personal events cannot be recalled.

9. Personality/Facititious Disorders

A. Personality disorders: the diagnostic criteria for the Personality Disorders refer to behaviors or traits that are characteristic of the person's recent (past year) and long-term functioning since early adulthood. The constellation of behaviors or traits causes either significant impairment in social or occupational functioning or subjective distress.

B. Factitious disorders: Factitious Disorders are characterized by physical or psychological symptoms that are intentionally produced or feigned. The sense of intentionally producing a symptom is subjective, and can only be inferred by an outside observer.

10. Pre-Adult (Attention/Childhood Anxiety/Conduct Disorders)

Existing disorders in children and youth.

11. Other Nonpsychotic Disorders - Adult and Pre-Adult

(1) Eating, movement, and other physical manifestations
(2) Developmental disabilities
(3) Childhood disorders other than previously defined
(4) Sexual disorders
(5) Adjustment disorders
(6) Nonpsychotic mental disorders other than previously defined

12. Social Conditions

Disorders as a result of social environment, for example, family disruption, marital problems, parent/child problems, and abuse.

13. No Mental Disorder

Self explanatory

14. Diagnosis Deferred

Self explanatory

Appendix C: Letter and Seminar Questionnaire

MONTANA
HEALTH
EDUCATION
CENTER

2304 West Main, Suite 6 Bozeman, MT 59715

(406) 586-3614

February 12, 1988

TO: Mental Health Professionals

FM: Gary A. Refsland, Director

RE: Mental Health Project

I am pleased to inform you that a grant for "Improving Mental Health Care Services to Montana Elders: New Strategies and Solutions to Enduring Problems" has been awarded to the Montana Department of Family Services by the Administration on Aging, Washington, D.C.

The 17-month, $149,769 project has been contracted to the Mental Health Center in Billings; John G. Nesbo, Center Director, will serve as Project Director, and a Program Assistant has been named in each of the five mental health centers. I will serve as Principal Investigator for the grant, which is being administered through the Montana Health Education Center.

The project is designed to promote better mental health among Montana's elderly, including off-reservation and on-reservation Indian elders, through a statewide public education campaign. Informational seminars will be held in each of the 56 counties and seven reservations in the State, along with a two-day conference focusing on mental health care problems. Qualitative and quantitative deficiencies of mental health care delivery in Montana will be identified, and strategies developed for providing improved services.

The public will receive information on mental care assistance via two-30 minute videotapes, 12 public service announcements, news articles and a brochure. We hope you will help us identify topics to be addressed in the 12 public service announcements for television. Based on your professional experience, what are the three subjects in the area of mental health and the elderly that can be developed into PSAs? Please list your ideas on the brief questionnaire included with this letter.

The project is also intended to define and deliver four educational seminars to Montana's approximately 950 mental health care providers. The day-long seminars will be presented at each mental health care center in five locations of the State. We would like to know what topic areas you would like to see addressed in the seminars. Please take a few minutes to review the list of suggested topics on the next page and check the four that are most interesting to you. The compiled results will be used by the Planning Committee in designing the professional seminars.

Thank you in advance for responding to the enclosed questionnaire. We would very much appreciate your returning it to us by February 26, 1988.

"Improving Mental Health Care Services to Montana Elders:
New Strategies and Solutions to Enduring Problems"

Please take 10 minutes or so to complete this brief questionnaire and return by February 26, 1988 to Gary A. Refsland, Principal Investigator, Montana Area Health Education Center, 2304 West Main, Suite Number 6, Bozeman, MT, 59715.

1. Listed below are suggested topic areas for day-long educational seminars. Please check the FOUR topics of most interest to you.

_____Review of normal aging: a baseline for assessing mental health problems of the elderly.

_____Innovative approaches to reaching the older adult: relaxation, guided imagery, music, storytelling, creativity as therapy.

_____Assessment strategies applicable to the aging: measurement of physical functioning, mental status, multidimensional measures.

_____Diagnosing and treating depression in the elderly.

_____Intervention strategies with bereavement, grieving, and object loss as mental health issues of aging.

_____Working with the caregiver: mental health services for adult children or spouses of frail or demented elderly.

_____Care strategies for Alzheimer patients: environmental adaptations, nonpharmaceutical, and appropriate pharmaceutical approaches.

_____Issues in mental health services for the rural elderly.

_____Developing "Gatekeeper Programs" in rural communities.

_____Suicide as a mental health problem of the elderly.

_____Dimensions of dementia.

_____Individual and group interventions with impaired elderly in different diagnostic categories and settings.

_____Mental health center on-site day treatment and off-site services to nursing home and in-home residents.

_____Therapy issues with the elderly: use of psychotherapy for out-patient older adults and other issues.

_____Spiritual needs of the cognitively impaired older adult.

2. Assuming that all of the four presentations to be scheduled are of interest to you, check four of the following nine months you are most likely to attend.

_____June, 1988 _____July, 1988 _____August, 1988

_____September, 1988 _____October, 1988 _____November, 1988

_____December, 1988 _____January, 1989 _____February, 1989

3. A total of four seminars will be held at each of the five community mental health centers in Montana. Please check the location(s) of seminars most convenient for you to attend.

_____Miles City _____Billings _____Helena _____Great Falls _____Missoula

4. What is your occupation?

_____psychiatrist _____psychologist

_____counselor/therapist _____physician

_____administrator/manager/director

_____other/ specify_____

_____geriatric specialist in the field checked above

_____psychiatric specialist in the field checked above

5. In what setting do you work?

_____community mental health center _____hospital

_____long term care facility _____senior residence

_____private practice _____mental institution

_____community-based in-home service

_____other/ specify _____

6. During the past two years, how often did you attend professional conferences or educational presentations?

Total number attended in-state?_____

Total number attended out-of-state?_____

Appendix D: Results of Survey

243/738 = 33% Return

"Improving Mental Health Care Services to Montana Elders:
New Strategies and Solutions to Enduring Problems"

1. Listed below are suggested topic areas for day-long educational seminars.
Please check the FOUR topics of most interest to you.

42%	103	A. Review of normal aging: a baseline for assessing mental health problems of the elderly.
37%	89	B. Innovative approaches to reaching the older adult: relaxation, guided imagery, music, storytelling, creativity as therapy.
39%	94	C. Assessment strategies applicable to the aging: measurement of physical functioning, mental status, multidimensional measures.
47%	113	D. Diagnosing and treating depression in the elderly.
37%	89	E. Intervention strategies with bereavement, grieving, and object loss as mental health issues of aging.
33%	80	F. Working with the caregiver: mental health services for adult children or spouses of frail or demented elderly.
19%	45	G. Care strategies for Alzheimer patients: environmental adaptations, nonpharmaceutical, and appropriate pharmaceutical approaches.
24%	59	H. Issues in mental health services for the rural elderly.
12%	28	I. Developing "Gatekeeper Programs" in rural communities.
9%	23	J. Suicide as a mental health problem of the elderly.
24%	58	K. Dimensions of dementia.
20%	48	L. Individual and group interventions with impaired elderly in different diagnostic categories and settings.
26%	62	M. Mental health center on-site day teatment and off-site services to nursing home and in-home residents.
33%	80	N. Therapy issues with the elderly: use of psychotherapy for out-patient older adults and other issues.
7%	16	O. Spiritual needs of the cognitively impaired older adult.

2. Assuming that all of the four presentations to be scheduled are of interest to you, check four of the following nine months you are most likely to attend.

40%	97	June, 1988
26%	63	July, 1988
30%	73	August, 1988
67%	162	September, 1988
62%	150	October, 1988
45%	109	November, 1988
15%	37	December, 1988
39%	95	January, 1989
47%	109	February, 1989
3%	8	No Response

3. A total of four seminars will be held at each of the five community mental health centers in Montana. Please check the location of seminar most convenient for you to attend.

23	Miles City	
55	Billings	
63	Helena	N=243
49	Great Falls	
53	Missoula	

4. What is your occupation?

12	Psychiatrist
40	Psychologist
72	Counselor/Therapist
1	Physician
18	Administrator/Manager/Director
71	Social Worker
7	Mental Health Worker - LPN
5	Psychiatric/Mental Health Nurse
2	Group Home Supervisor/Recreation Therapist
10	Registered Nurse

1	Vocational Specialist
2	Chemical Dependency Counselor
1	Therapeutic Recreation Therapist
3	Psychiatric Aid
3	No Response
4	Geriatric Specialist in the field checked above
4	Geriatric Social Worker
3	Geriatric Counseling Therapist
8	Psychiatric Specialist in the field checked above
4	Psychiatric/Mental Health Nurse: Billings, (2) Great Falls
4	Psychiatric Social Worker

5. In what setting do you work?

80	Community mental health center
27	Hospital
4	Long Term Care Facility
1	Senior Residence
46	Private Practice
2	Mental Institution
13	Community-based in-home service
1	River House - Day Treatment Program
33	Department of Family Services
7	State/County Agency
3	Residential Treatment Center for Children
2	Private Agency
3	MSU College of Nursing
1	Out-Patient Residential Facility for CMI (18-70 years)
5	Indian Health Service
1	Consulting
7	School/Elementary and Secondary
1	Correctional Facility
2	Dept. of Health Surveyor
1	Women's Clinic
3	Day Treatment
1	Employee Assistance Program
4	No Response

6. During the past two years, how often did you attend professional conferences or educational presentations?

Total number attended in state? 827/243 = 3.403 = 1.702 per year

Total number attended out-of-state? 210/243 = .864 = .432 per year

PSA's

I feel mental health services for the elderly should be developed and available before PSAs are produced.

2 Elder Abuse

Intervention strategies with bereavement, grieving, and object loss as mental health issues of aging.

Working with the caregiver: mental health services for adult children or spouses of frail or demented elderly.

Review of normal aging: a baseline for assessing mental health problems of the elderly.

2 Depression and the elderly.

Coping with stress and loss.

Recreational opportunities for the elderly.

Self-esteem tips.

Increase public awareness of the difference between mental illness, senility and normal aging.

Improve respect for the elderly by showing lack of same in our culture vs. honored status of elderly in other cultures.

Encourage utilization of the talents, skills, abilities of the elderly past retirement age and help break down the put-out-to-pasture stereotype.

Rights of the elderly.

Alcoholism among the elderly.

Appendix E: First Seminar, "Normal Aging: A Baseline for Assessing Mental Health Problems of the Elderly"

MONTANA
HEALTH
EDUCATION
CENTER

2304 West Main, Suite 6 Bozeman, MT 59715

(406) 586-3614

April 25, 1988

TO: Mental Health Professionals

FM: Gary A. Refsland, Director

RE: "Improving Mental Health Care Services to Montana Elders: New Strategies and Solutions to Enduring Problems"

The results of the survey of mental health professionals conducted last February for the project have been compiled. One third of the 738 persons surveyed responded regarding the topics of most interest to them for training in the area of mental health care services to Montana elders.

We are pleased to announce that the first of four educational seminars funded by the project is scheduled for June 1988, on the most requested topic: "Review of Normal Aging: A Baseline for Assessing Mental Health Problems of the Elderly".

Dr. Amanda Barusch, Chairperson of the Gerontology Emphasis, Graduate School of Social Work, University of Utah, will be the presentor of the seminar at the following four sites:

Missoula: June 6, 10:00 am - 5:00 pm, Village Red Lion Motor Inn
Helena: June 7, 9:00 am - 4:30 pm, St. Peter's Community Hospital
Great Falls: June 8, 9:30 am - 4:30 pm, Heritage Inn
Miles City: June 9, 9:30 am - 4:30 pm, Community College, Room 106

Dr. Victoria Coffman, Professor of Communication Arts, Eastern Montana College; Mary Freund, R.N., Geriatric Nurse Practitioner, Billings Clinic; and Dr. Judith A. McLaughlin, Assistant Professor of Psychology, Eastern Montana College, will be the presentors of the seminar at the following site:

Billings: June 9, 8:00 am - 5:00 pm. Deaconess Medical Center, Mary Alice Fortin Health Conference Center

You are invited to attend the seminar in June at the location most convenient for you. There is no registration fee. Funding is provided through a grant awarded by the Administration on Aging to the Montana Department of Family Services, contracted to the Mental Health Center, Billings, and administered by the Montana Area Health Education Center, Bozeman. Project assistants are located at each of the five mental health centers.

You are requested to return the enclosed registration form by May 27, 1988. If you are unable to pre-register, please call the Montana Area Health Education Center at 586-3614 after June 1 to see if space is available.

NORMAL AGING: A BASELINE FOR ASSESSING MENTAL HEALTH PROBLEMS OF THE ELDERLY

Amanda Barusch, D.S.W., Assistant Professor of Social Work,
University of Utah

Missoula: June 6, 10:00-5:00, Village Red Lion Motor Inn
Helena: June 7, 9:00-4:30, St. Peter's Community Hospital
Great Falls: June 8, 9:30-4:30, Heritage Inn
Miles City: June 9, 9:30-4:30, Community College, Room 106

I. Introductions: Mental Health Center Director and Project Assistant

II. Lecture and slide presentation: **Is There Normal Aging?**

III. **Psychological Dimension:**
- Psychological Developmental Tasks
- Psychological Self-Concept
- Psychological Meaning

IV. **Group Exercise with Case Study**

Lunch Break

V. **Social Dimensions of Aging**
Challenges Confronting the Aging Family: Adaptive v. Dysfunctional Coping Mechanisms
Significant Life Events

VI. **Contrasting Normal Changes with Pathological Conditions**

VII. **Appreciation: Assessment and Treatment Strategies**

VIII. **Closing Exercise**

LEARNING OBJECTIVES

I. Knowledge: Participants in this session will enhance their understanding of :

A. Normal physiological changes that occur in old age
B. Normal cognitive changes that occur in old age
C. Common psychological issues confronted by the elderly
D. Guidelines for distinguishing normal aging from pathological conditions
E. Common dynamics which affect families of the elderly
F. Adaptive and dysfunctional family dynamics

II. Skills: Participants will improve their ability to:

A. Identify and describe the normal changes which come with age
B. Assess individual and family functioning in later years

NORMAL AGING: A BASELINE FOR ASSESSING MENTAL HEALTH PROBLEMS OF THE ELDERLY

Mary Alice Fortin Health Conference Center, Deaconess Medical Center
Billings, Montana

Thursday, June 9, 1988

8:00 a.m. - 8:30 a.m.	**Arrival and Registration**
8:30 a.m. - 9:00 a.m.	**Welcome** **"Introduction to AoA Mental Health and Aging Grant,"** John G. Nesbo, Executive Director, Region III MHC; Sharon Harris, RN, MN, Clinical Coordinator of Older Adult Services, Region III MHC
9:00 a.m. - 11:00 a.m.	**"Empathetic Understanding of the Aging Process: Sensory Deprivation Exercises,"** Victoria Coffman, PhD, Professor of Communication Arts, Theatre, Eastern Montana College Coffee break scheduled during presentation
11:00 a.m. - 12:30 p.m.	**"Physical Changes and Their Implication in Aging,"** Mary Freund, R.N., Geriatric Nurse Practitioner, Billings Clinic
12:30 p.m. - 1:30 p.m.	**Lunch on your own**
1:30 p.m. - 3:45 p.m.	**"Thinking and Feeling in the Elderly: Myth vs. Reality,"** Judith A. McLaughlin, PhD, Assistant Professor of Psychology, Easter Montana College Coffee break scheduled during presentation
3:45 p.m. - 4:45 p.m.	**Summary and Evaluation**

SEMINAR REGISTRATION FORM

"Review of Normal Aging:
A Baseline for Assessing Mental Health Problems of the Elderly"

PLEASE RETURN THIS REGISTRATION FORM BY MAY 27, 1988, TO:

Montana Area Health Education Center
2304 West Main Street, Suite 6
Bozeman, Montana
Telephone: 586-3614

NAME:_____ POSITION:_____

ORGANIZATION:_____ PHONE:_____

ADDRESS:_____

_____

Location and date of seminar you plan to attend (please check one!):

	Person to Contact for further information	
_____ Missoula (June 6)	David Washburn	728-6817
_____ Helena (June 7)	Sue Bennett	723-5489
_____ Great Falls (June 8)	Linda Hatch	761-2100
_____ Miles City (June 9)	Jim Mount	232-1687
_____ Billings (June 9)	Sharon Harris	252-5658

**Continuing education credits for social workers, professional counselors, chemical dependency counselors, and nurses have been applied for.

TYPE OF CE CREDITS DESIRED:_____

TOTAL ATTENDANCE BY POSITION

MENTAL HEALTH SERVICES ATTENDANCE BY POSITION

ACTIVITY COORDINATOR	1
ADMINISTRATIVE OFFICER	1
ADULT SERVICES SUPERVISOR	1
AGING SERVICES SPEC	1
AIDE	3
ASSISTANT DIRECTOR	2
ASST. PROFESSOR	2
CD/MH PROGRAM ADM	1
CHAIRPERSON	2
CHR	3
CLINICAL DIRECTOR	1
CLINICAL PRAC. SUP.	1
CLINICAL PSYCH	1
COUNSELOR	12
DENTAL ASSISTANT	1
DIRECTOR	18
DISTRICT SUPERVISOR	1
E.I./E.I.	2
FAMILY SERVICE SPEC	1
FOOD SAISER	1
GENERALIST	1
GROUP HOME MANAGER	1
HEALTH ADM.	1
HEALTH EDUCATOR	1
HOME ATTENDANT	1
HOME SERVICES DIRECTOR	1
LONG TERM SPEC CARE	1
LPC	2
MSC	1
MUSIC THERAPIST	1
NURE	11
NURSE	46
OPTOMETRY	1
PASTOR	1
PROFESSOR	3
PROGRAM MANAGER	6
PSYCH. ASST.	4
PSYCHOLOGIST	18
PSYCHOTHERAPIST	1
SECRETARY CHR	1
SOCIAL WORKER	81
SP	1
STAFFING SPECIALIST	1
STUDENT	1
SUPERVISOR	1
THERAPEUTIC REC.	1
THERAPIST	8
VOLUNTEER COORDINATOR	1
TOTAL	248

Appendix F: Second Seminar, "Psychological Assessment Strategies Applicable to the Aging"

MONTANA HEALTH EDUCATION CENTER

Montana Office of Rural Health
2304 West Main, Suite 6 Bozeman, MT 59715
(406) 586-3614 Fax (406) 586-3630

ANNOUNCING...

The second of four seminars for mental health professionals:

PSYCHOSOCIAL ASSESSMENT STRATEGIES APPLICABLE TO THE AGING

Joan Nell, OTR/L MPH, Program Manager, Older Adult Services,
Seattle Mental Health Institute

Funded by the grant, "Improving Mental Health Care Services to Montana Elders: New Strategies and Solutions to Enduring Problems."

For the past ten years, the presenter has supervised and conducted older adult mental health programs which include day treatment on site at the community mental health center and in nursing homes; group and individual therapy; consultation and training to agency staff and community education. She has previously presented 2-day workshops for the University of Washington Institute on Aging on "Basic Interviewing and Assessment", and has conducted numerous workshops on topics such as death and dying, conflict management, the dementias, behavioral management of difficult patients, stress management, the psychoses, and depression.

The seminar on mental health assessment strategies applicable to the aging will be presented from 9:30 a.m. to 4:30 p.m. at the following locations:

Sept. 12	Miles City	- Community College, Room 106
Sept. 13	Billings	- St. Vincent Hospital and Health Center Marillac Hall Auditorium
Sept. 14	Great Falls	- Columbus Hospital, Lewis & Clark Auditorium
Sept. 15	Helena	- Department of Natural Resources and Conservation, 1520 E. 6th Avenue
Sept. 16	Missoula	- St. Patrick Hospital, Broadway Building

Please complete the enclosed registration form and return it by September 7th; registrations will also be accepted at the door if space is available. There is no registration fee for the seminar since funding is provided through a grant awarded by the Administration on Aging to the Montana Department of Family Services and contracted to the Mental Health Center in Billings, with assistance from the mental health centers in Missoula, Helena, Great Falls, and Miles City.

The next seminar in this series is scheduled for October 4th in Missoula and October 6th in Billings on the topic of "Diagnosis and Treatment of Depression in the Elderly" presented by Dr. James Slaughter, Assistant Professor, Department of Psychiatry, University of Utah School of Medicine; Medical Director, Older Adult Evaluation and Treatment Clinic, Western Institute of Neuropsychiatry; Chief of Consultation Liaison Psychiatry, Veterans Administration Medical Center, Salk Lake City, Utah.

PSYCHOSOCIAL ASSESSMENT STRATEGIES APPLICABLE TO THE AGING

Joan Nell, OTR/L MPH, Program Manager, Older Adult Services
Seattle Mental Health Institute

AGENDA

I. Introduction and Agenda Review

II. Basic Interviewing Techniques

III. Assessment Tools: Intake Documents, Mental Status Examinations, Psychosocial Evaluations

IV. Practicing Interviewing Techniques

V. DSM III - R.

VI. Psychotherapeutic Treatment Planning

Objectives: Participants in this session will enhance their:

I. Knowledge

A. Factors that need to be considered in a psychosocial assessment of older adults

B. Observable indicators of disability

C. Assessment tools used in evaluating dysfunction in older adults

D. Uses of DSM III - R. for diagnosis

II. Skills: Participants will improve their ability to:

A. Interview older adults

B. Assess older adult dysfunction

C. Translate knowledge concluded from an assessment into a treatment plan

SEMINAR REGISTRATION FORM

"Psychosocial Assessment Strategies Applicable to the Aging"

PLEASE RETURN THIS REGISTRATION FORM BY SEPTEMBER 7, 1988, TO:

Montana Area Health Education Center
2304 West Main Street, Suite 6
Bozeman, MT 59715
Telephone: 586-3614

NAME: _____ POSITION: _____

ORGANIZATION: _____ PHONE: _____

ADDRESS: _____

_____

LOCATION AND DATE OF SEMINAR YOU PLAN TO ATTEND (please check one):

		Person to contact for further information:	
_____ Miles City	(Sept. 12)	Jim Mount	232-1687
_____ Billings	(Sept. 13)	Sharon Harris	252-5658
_____ Great Falls	(Sept. 14)	Linda Hatch	761-2100
_____ Helena	(Sept. 15)	Sue Bennett	723-5489
_____ Missoula	(Sept. 16)	David Washburn	728-6817

**Continuing education credits for social workers, professional counselors, chemical dependency counselors, and nurses have been applied for.

TYPE OF CE CREDITS DESIRED: _____

TOTAL SEMINAR PARTICIPATION BY POSITION

"Psychological Assessment Strategies Applicable to the Aging"

September 12-16, 1988

Position	Total Number of Participants
Activity Aide	1
Activity Director	2
Administrative/Office Director	2
Assistant Program Director	2
Associate Professor	1
Case Manager	2
Clinical Coordinator/Director	2
Counselor	11
Director, Clinical Support Services	1
Director, Day Treatment	1
Director, Nursing	3
Director, Rehabilitation	1
House Manager	1
Home Health Attendant	3
Job Club Coordinator	1
Long Term Care Specialist	1
Medical Director	1
Head Nurse	1
Nurse	28
Nurse Aide	2
Public Health Nurse	1
Case Management Nurse	1
Public Health Program Assistant	2
Occupational Therapist	1
Clinical Social Worker	6
Medical Social Worker	4
Social Worker	54
Adult Protection Unit Social Worker	3
Social Worker Supervisor	1
Social Services Consultant	2
Social Services Designee/Director	9
Student	2
Clinical Psychologist	2
Psychologist	3
Psychiatric Aide	4
Psychotherapist	3
Director, Psychosocial Services	1
Recreation Director	1
Recreational Therapy Aide	1
Therapist	5
None	25
Total:	198

Appendix G: Third Seminar, "Diagnosis and Treatment of Depression in the Elderly"

MONTANA
HEALTH
EDUCATION
CENTER

2304 West Main, Suite 6 Bozeman, MT 59715
(406) 586-3614 Fax (406) 586-3630

We are pleased to invite you to participate . . .

in a special seminar for mental health professionals:

DIAGNOSIS AND TREATMENT OF DEPRESSION IN THE ELDERLY

Presented by James R. Slaughter, M.D.

Dr. Slaughter is an Assistant Professor, Department of Psychiatry, University of Utah School of Medicine; Medical Director, Older Adult Evaluation and Treatment Clinic, Western Institute of Neuropsychiatry; Chief of Consultation Liaison Psychiatry, Veterans Administration Medical Center, Salt Lake City, Utah.

Funding is provided by the grant, "Improving Mental Health Care Services to Montana Elders: New Strategies and Solutions to Enduring Problems."

The day-long seminar on diagnosis and treatment of depression in the elderly will be presented from 9:30 a.m. to 4:30 p.m. At the speaker's request, the dates for the seminar have been changed from October 4 and 6 to October 11 and October 13. The seminar on October 11 will be held in Missoula at Community Hospital, 2827 Fort Missoula Road, Missoula; Dr. Tom Roberts, a geriatric specialist, will participate in the presentation. The seminar on October 13 will be held in Billings at the Billings Clinic, 2825 8th Avenue North, Billings, with participation from a specialist associated with the Community Mental Health Center.

There is no registration fee for the seminar since funding is provided through a grant awarded by the Administration on Aging to the Montana Department of Family Services and contracted to the Mental Health Center in Billings, with assistance from the community mental health centers in Missoula, Helena, Great Falls and Miles City.

For further information, you may contact:

Jim Mount, Eastern MT Community MHC, Miles City	232-1687
Sharon Harris, South Central Community MHC, Billings	252-5758
Linda Hatch, Golden Triangle Community MHC, Great Falls	761-2100
Sue Bennett, Mental Health Services, Inc., Butte	723-5489
David Washburn, Western MT Community MHC, Missoula	728-6817

Please complete the enclosed registration form and return it by October 7, 1988, to the Montana Area Health Education Center. Registrations will also be accepted at the door if space is available.

SEMINAR REGISTRATION FORM

DIAGNOSIS AND TREATMENT OF DEPRESSION IN THE ELDERLY

Presented by James R. Slaughter, M.D., Assistant Professor, Department of Psychiatry, University of Utah School of Medicine

9:30 a.m. - 4:30 p.m.

Tuesday, October 11, Missoula
Thursday, October 13, Billings

PLEASE RETURN THIS REGISTRATION FORM BEFORE OCTOBER 7, 1988:

Before October 3, 1988 to:

Montana Area Health Education Center
2304 West Main Street, Suite 6
Bozeman, Montana 59715
Telephone: 586-3614

After October 3, 1988 to:

Montana Area Health Education Center
Culbertson Hall, Room 308
Montana State University
Bozeman, Montana 59717
Telephone: 994-6001

NAME: _____

POSITION: _____

ORGANIZATION: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE: _____

LOCATION AND DATE OF SEMINAR YOU PLAN TO ATTEND (Check One):

____ **October 11, Community Hospital, 2827 Fort Missoula Rd., Missoula**
____ **October 13, Billings Clinic, 2825 8th Ave. N., Billings**

TYPE OF CE CREDITS DESIRED** _____

**Continuing education credits for social workers, professional counselors, chemical dependency counselors and nurses have been applied for.

TOTAL ATTENDANCE BY POSITION

"Diagnosis and Treatment of Depression in the Elderly"

Presented by James R. Slaughter, M.D.

MISSOULA

October 11, 1988

BILLINGS

October 13, 1988

ACTIVITY DIRECTOR	3
ADMINISTRATIVE ASSISTANT	1
CASE MANAGEMENT NURSE	1
CASE MANAGEMENT SOCIAL WORKER	1
CASE MANAGER	2
CLINICAL COUNSELOR	2
CLINICAL PSYCHOLOGIST	1
CLINICAL SOCIAL WORKER	4
COMMUNITY CARE SOCIAL WORKER	1
COUNSELOR	15
DIRECTOR OF SOCIAL SERVICES	1
HEAD NURSE	1
HEALTH CARE SURVEYOR	2
HOME ATTENDANT	5
JOB CLUB COORDINATOR	1
MEDICAL DIRECTOR	1
MEDICAL SOCIAL WORKER	1
MENTAL HEALTH TECHINICIAN	1
NONE	14
NURSE	22
PHYSICIAN	3
PSYCHIATRIC AIDE	2
PSYCHIATRIC CLINICAL SPECIALIST	1
PSYCHIATRIC NURSE	1
PSYCHIATRIC SOCIAL WORKER	1
PSYCHOLOGIST	6
REGIONAL CLINICAL DIRECTOR	1
REHABILITATION AIDE	1
REHABILITATION THERAPOST	1
SOCIAL SERVICES DESIGNEE	2
SOCIAL WORKER	25
STUDENT	3
THERAPIST	1
COORDINATOR OF COUNSELING EDUCATION	1
OFFICE DIRECTOR	1
TOTAL	130

Appendix H: Fourth Seminar, "Loss and Grief as Related to the Aging Population"

A SEMINAR FOR MENTAL HEALTH PROFESSIONALS

"Loss and Grief as Related to the Aging Population"

Presented by Karen L. Kent, M.S.G.

Karen Kent is currently Department Manager, Older Adult Services, Eastside Mental Health, Bellevue, WA. She has presented numerous seminars and workshops in the field of mental health and aging. Her present position evolved out of progressive promotions from therapist to program co-ordinator to department manager. She supervises staff, volunteers and students in day treatment, nursing homes and outpatient programs, and provides consultation, education and clinical services to community, families and older adults.

The seminar is to be presented from 9:30 a.m. to 4:30 p.m. at the following five locations:

Feb 6	Miles City	-	Community College, Room 106
Feb 7	Billings	-	Marillac Auditorium, St. Vincint Hospital and Health Center
Feb 8	Great Falls	-	Columbus Hospital, Lewis and Clark Room,
Feb 9	Helena	-	St. Peter Hospital Meeting Room
Feb 10	Missoula	-	St Patrick Hospital Meeting Room

There is no registration fee for the seminar since funding is provided by the grant, "Improving Mental Health Care Services to Montana Elders: New Strategies and Solutions to Enduring Problems." The grant was awarded by the Administration on Aging to the Montana Department of Family Services and contracted to the Mental Health Center in Billings, with assistance from mental health centers in Missoula, Helena, Great Falls, and Miles City.

For further information, contact:

Jim Mount, Eastern MT Comm M H C, Miles City	232-1687
Sharon Harris South Central Comm M H C, Billings	252-5658
Linda Hatch, Golden Triangle Comm M H C, Great Falls	761-2100
Sue Bennett, Mental Health Services, Inc. Butte	723-5489
David Washburn, Western MT Comm M H C, Missoula	728-6817

Please complete the enclosed registration form and return it by February 1, 1989 to the Montana Area Health Education Center. Registrations will be accepted at the door if space is available.

LOSS AND GRIEF AS RELATED TO THE AGING POPULATION

Agenda

I. Introductions and Agenda Review

II. Losses with Age

III. Phases of Mourning

IV. Healing Process

V. Unresolved Grief

VI. Program Approaches to working with the Older Adult

Objectives

I. Participants will enhance their knowledge of:

- A. Age-related differences with bereavement
- B. Emotions of grief
- C. Normal versus abnormal grief
- D. Healing process
- E. Program approaches

II. Participants will improve their skills in:

- A. Assessing the difference between healthy grief and unhealthy grief
- B. Identifying which people need extended therapy
- C. Helping people work through the grief process

SEMINAR REGISTRATION FORM

"Loss and Grief and Related to the Aging Population"

Presented by Karen L. Kent, M.S.G., Department Manager, Older Adult Services, Eastside Mental Health, Bellevue, Washington

9:30 a.m. - 4:30 p.m.

PLEASE RETURN THIS REGISTRATION FORM BY FEBRUARY 1, 1989, TO:

Montana Area Health Education Center
Culbertson Hall, Room 308
Montana State University
Bozeman, Montana 59717
Telephone: 994-6001

NAME: _____

POSITION: _____

PHONE: _____

ORGANIZATION: _____

ADDRESS: _____

CITY, STATE, ZIP _____

LOCATION AND DATE OF SEMINAR YOU PLAN TO ATTEND (check one):

Person to contact for further information:

_____ Miles City (Feb 6) Jim Mount 232-0234
_____ Billings (Feb 7) Sharon Harris 252-5658
_____ Great Falls (Feb 8) Linda Hatch 761-2100
_____ Helena (Feb 9) Sue Bennett 723-5489
_____ Missoula (Feb 10) Dave Washburn 728-6817

**Continuing education credits for social workers, professional counselors, chemical dependency counselors, and nurses have been applied for. TYPE OF CE CREDITS DESIRED _____

TOTAL SEMINAR PARTICIPANTS

"Loss and Grief as Related to the Aging Population"

Total Participants: 245

Position

Activity Aide	1
Activity Coordinator	3
Activity Director	3
Adult Care Supervisor	1
Adult Day Coordinator	1
Administrator	I
Assistant Administrator	1
Coordinator	1
Case Management	3
Clinical Director	2
Director	3
Director, Nursing	4
Director, Social Services	4
Counselor	24
Employee Assistance Counselor	1
Geriatric Clinician	1
Instructor	1
Human Services Aide	5
Head Nurse	1
Nurse	34
Nurse Aide	2
Psychiatric Aide	3
Psychologist	1
Psychotherapist	1
Director, Psychosocial Services	1
Senior Companion	6
Senior Advocate	1
Rehabilitation Aide	1
Intensive Care Manager	1
Pastor	2
Student	6
Clinical Social Worker	5
Medical Social Worker	4
Social Worker	59
Social Services Designee	5
Supervisor	2
Unit Supervisor	1
Volunteer Coordinator	1
Social Work Consultant	2
Social Work Supervisor	1
Social Work Aide	1
Staff Development	1
Surveyor	1
Therapist	2
None	40

Appendix I: Newspaper Articles

GOOD MENTAL HEALTH FOR OLDER MONTANANS-LEISURE AND RECREATION FOR THE MENTAL WELL BEING OF THE ELDERLY

Physical and mental well being go hand in hand. Effective use of leisure and recreational time leads to better physical and mental health. This is no less important for those who are older than for those who are young. Although Montana abounds with leisure and recreational opportunities, better use could be made of them by Montana's older adults.

A White House mini-conference held in 1981 focused on the topics of recreation, leisure, and physical fitness. The conference theme emphasized the importance of leisure lifestyle. Activity and exercise significantly correlate with high morale in the aged. In reality, however, there is an overall shortage of wellness and preventive health program opportunities for older persons. Being elderly with "time on one's hands" may result in feelings of alienation and worthlessness. Because of the "work ethic" in the United States, older Americans have not learned to "leisure."

The following lifestyle components were identified at the mini-conference as factors useful for evaluating leisure and recreation programs:

Time: having the potential for leisure and recreational experiences and having a future orientation. Leisure programs should be effective in dealing with basic attitudes about the use

of increased time for self expression and life satisfaction.

Experiences: focusing on activity patterns and the human relationships that may be characterized by independent, corresponding, and interactive leisure activities. Older people need opportunities for seclusion, as well as for intense contact with others.

Preferences: offering viable leisure programs which provide what the consumer wants to do with time.

Satisfaction: recognizing the important psychological factors that contribute to the general feeling of competence that older Americans have in their leisure and recreation.

A good beginning point in maintaining physical well being for older Montanans is through preventative living. Preventative living comes through a combination of exercise, maintaining a good, nutritious diet, quality selfcare, and a partnership with a physician to obtain appropriate health care.

Mental well being involves relaxation, rejecting unnecessary limitations, creating positive expectations, maintaining memory, coping with loss and life change, and effective communication.

Research has shown that similar high levels of well being are attained by different sexes and different ethnic groups in

different ways: there is no single pattern for aging. However, certain behaviors are found in those who display and report satisfaction in aging. Some psychosocial adjustments that can be made to help in coping with the aging process are recognition of one's own aging with physical and social limits, acceptance of new perceptions of self, commitment to meaningful goals and values that can be communicated and shared with others, and development of an ability to skillfully confront change.

For those with physical and mental well being, old age can be a valuable stage of life. For additional information, contact your nearest Montana Community Mental Health Care Center.

GOOD MENTAL HEALTH FOR OLDER MONTANANS-DEPRESSION

Depression has been called the "common cold" of psychiatry because it is the most common disorder seen by mental health practitioners. With the growing number of Americans over the age of 65, a high incidence of geriatric depression has become a major concern in the United States. Affective disorders are not organic disorders, but are related to stress and loss in older persons. The principal manifestation is mood disturbance. It is estimated that 10-20% of the United States population experiences at least one episode of major affective disorder. The overall mortality rate of depressed persons is greater, with 7-15% committing suicide, while only 1-1.5% of the general population commits suicide. Additionally, depression is more common among elderly than younger persons.

A variety of causes may result in a higher prevalence among the elderly, such as multiple losses, prolonged grieving, reduction in physical vigor, retirement, reduction in income, and social isolation. Common symptoms include poor appetite, loss of weight, loss of pleasure or interest, feelings of worthlessness, guilt, indecisiveness, decrease in sex drive, and suicidal thoughts. Complications in diagnosis may occur with an elderly client when there is overlap with symptoms similar to a organic brain disorder such as dementia.

Because of the difficulty of diagnosing psychiatric disorders in the elderly, depression often becomes debilitating and disabling

before it is recognized and treated. It often accompanies illness. Older persons can withstand retirement and loss of loved ones better than loss of health and physical mobility. Physical disability can lead to social isolation which can lead to lowered self esteem. These factors in combination may result in depression.

The clinical picture of depression varies a great deal from person to person, particularly among older persons. The most common symptoms are sadness, withdrawal, lack of interest, inhibition of activity, pessimism, decreased self esteem, and poor self prognosis. There are, in addition, some primarily physical signs such as sleeplessness, loss of appetite, and weight loss or gain. Often, fatigue, constipation, and movement disorders are present. Daily mood cycles occur.

An even more severe form of depression called melancholia may occur in the elderly. Symptoms are similar to those for depression, but are more severe and pronounced.

The challenge of diagnosing depressive states in the elderly is confounded by the similarity in symptoms with those common for old age. However, the impression one gets in interacting with a depressed older person is that the person is "stuck," unable to decide whether to say or not to say, whether to do or not to do, something. The older individual who rises feeling tired and gloomy is likely to be depressed rather than to be normally aging.

Depression is often misdiagnosed as dementia. This occurs so frequently that professionals have labeled it "pseudodementia." Depressives commonly outperform the organically impaired because their handicaps are slowness and apathy rather than actual cognitive loss.

Another form of depression is anxious depression. This occurs in older persons frequently as a result of life review that finds unattained goals and evokes feelings of being trapped in a cycle of despair and anxiety. Depression may occur in combination with other somatic complaints such as hypochondriasis, an anxious preoccupation with one's own body which the person believes to be diseased. Elderly people will often seek a physician's help for a depressed condition. Depression can be successfully treated through a combination of anti-depressant medication and therapy. Occasionally, if the risk is sufficiently severe, for example, refusal to eat when the person is seriously malnourished, electroshock therapy may be used. However, most patients respond well to the combination treatment of drugs and therapy.

Awareness, recognition, and early intervention are keys to the successful treatment of depression. If depression remains undiagnosed and untreated, it may develop into a permanent debilitative and degenerative condition. The risk of suicide is much higher among depressed persons. Depression can be successfully treated even in those with organic impairment by a

combination of anti-depressant drugs and both individual and group therapy.

GOOD MENTAL HEALTH FOR OLDER MONTANANS-ALCOHOLISM AMONG THE ELDERLY

Alcoholism is the third most prevalent disease in this country. Although it is often thought of as a younger person's disease, an estimated 3 million American men and women over age 60 are affected by alcoholism. Approximately 3% of older adults treated at Montana's Community Mental Health Care Centers in 1987 were diagnosed as suffering from alcohol abuse or alcohol-related mental problems.

Alcoholism among Montana's elderly has often been referred to as the "unseen disease." Because the elderly are not as visible as the younger generation, their drinking is often hidden from view. The elderly who lived through the Prohibition Era and the rigid standards it imposed are often ashamed of their drinking and wish to hide it. Many older women have believed their entire lives that alcohol use is unacceptable and may refuse to admit they have a drinking problem.

Older people in institutions, widowers, and people with medical problems have a high incidence of alcohol abuse. Widowers over the age of 75 have the highest rate of alcoholism in the country.

Alcohol behaves differently in the elderly. Since alcohol cannot clear as fast, blood alcohol will remain higher longer and they will get drunk more quickly. In a study of the effects of

alcohol on various age groups, standard doses were administered intravenously to people of different ages. It was found that the older the person the greater the resulting diminution of physical and mental function.

The elderly consume 25 to 33% of all prescription medications, according to various estimates. The combination af alcohol and medications (even over-the-counter sleeping pills) may be dangerous and can lead to decreased intellectual functioning.

Among the health risks included in alcoholism is a clear link with suicide. Alcoholics have significantly higher suicide rates than do non-alcoholics (up to 58 times greater in some groups of alcoholics).

Many stresses associated with aging have been cited as risk factors for alcohol abuse by older adults. Poor health, retirement, and bereavement for friends and relatives are but a few. The loss of status accompanying aging in a youth-oriented society may also contribute to anxieties experienced by the elderly.

Two types of elderly alcoholics are recognized: early onset and late onset. Early onset alcoholics refers to those persons who have been drinking all of their lives; they may have had drinking and personality difficulties since their younger days. The role of alcohol may have seemed "normal" in their social

sphere. Late onset alcoholics may have been social drinkers earlier, or may not have touched alcohol at all; their drinking problem may be a response to grief and loss.

Alcohol enhances feelings of isolation, loneliness, and boredom, conditions that may have precipitated drinking in the first place. Resulting can be a destructive cycle of increased withdrawal and greater alcohol intake to deaden the awareness and grief associated with solitude.

Social isolation, physical deterioration, malnutrition, memory loss, and depression are some of the symptoms associated with alcoholism. Often, the effects of alcohol may be overlooked in an elderly person because the symptoms are attributed as consequences of aging and chronic illness.

Other problems exist in confronting the disease. Very often, alcoholism is kept within the family, hidden from outsiders. In addition, health care professionals may forget to ask their patients about their drinking habits; a thorough evaluation and history of alcohol consumption might never be made.

Denial that a drinking problem exists may be reinforced by an older person's unwillingness to admit that he or she cannot handle alcohol, after years of handling so many other things in their lives. Elderly drinkers may echo the claim of most alcoholics: "I can quit any time I want to."

Many experts feel that the best way to approach alcoholism in the elderly is to treat it as a medical condition and involve the family and a doctor. Viewing alcoholism as a disease rather than a "moral weakness" is essential for assisting the alcoholic to obtain help.

Group therapy can be one of the most beneficial and effective ways of dealing with alcoholism. In addition to providing psychological and emotional support, a group situation may also help rebuild trust and establish communication with others.

It has been suggested that education prior to retirement may help prevent elderly alcoholism; the media could be beneficial in this endeavor. Support by family and friends in helping individuals confront their problems may help prevent alcohol abuse in older as well as younger people.

Numerous sources of help and assistance are available for those suffering from this debilitating disease. If you or someone you know suffers from any form of alcohol abuse, contact your nearest Montana Community Mental Health Care Center. Thirty-four mental health care facilities are located throughout Montana.

GOOD MENTAL HEALTH FOR OLDER MONTANANS-LOSS AND GRIEF

In general, older people are healthier today than ever before. Thanks to modern science, most elderly are increasingly likely to stay healthy, active, vigorous, and involved well into their 70s and even their 80s. Today, approximately 126 thousand older adults reside in Montana, more than 16% of the population.

Although most older Montanans have good mental health, a number of psychological, physical, and sociological changes may face the elderly. How they adapt and adjust to these changes can have a significant impact on their mental well being. Difficulty in making these adjustments is one of the leading mental health problems among Montana's older adults.

Certainly, grief that results from the loss of a loved one is one of life's most traumatic and demanding emotional experiences. As we age, however, we begin to experience more frequent losses. We increasingly begin to lose friends and acquaintances.

Loss is an integral part of human experience that has profound consequences from birth to death. The most common stresses afflicting the elderly are losses of one kind or another. How people react to the stresses they encounter depends on their personal skills and on supportive networks; for some, it is conceivable that the challenges of becoming old may even engender new-found strengths. For the majority, however, weaknesses carried

over from earlier life tend to be magnified by old age.

The accumulation of losses is a process encountered by all elderly. Some losses are obvious, while some go unnoticed. The two most common to nearly everyone are the death of a loved one and the loss of physical health. In addition, elderly experience other social stresses of late life: income loss, the loss of role and status, isolation through disability, and the loss of cognitive function.

Loss and change in every aspect of life can have adverse affects, but elderly expend a good deal of energy grieving and adapting to changes resulting from loss. When several losses occur simultaneously, added emotional strain is imposed on the older person. Loss of physical health may occur at the same time as the death of a spouse, for example. Compounded losses may precipitate emotional and mental decline. The loss of a driver's license due to a physical disability may force isolation and result in loneliness. Gradually the elderly person's world contracts, often with diminished feelings of self worth.

Retirement is a major marker in the lives of many men and women. Although most people look forward to retirement, many are ill prepared for the enormity of the day-to-day changes they encounter. Some may view retirement as a drop in status. The decrease in income which accompanies retirement places an additional burden on the elderly, often leading to dependence on

others. Because Western culture values independence and self esteem, the aged are sometimes thought of as inferior when they can no longer care for themselves.

Loss must be faced, thought about, and reckoned with in order to avert future complications. The individual who suffers one or more functional losses may react with loss of self esteem, grief, or depression. Depression is the most common pathological reaction to loss. It is believed by many clinicians that factors in the psychosocial environment can lead to the development of diseases that cause premature death among the elderly.

The normal and healthy response to a loss is to grieve. Grieving is a natural and healthy component of the mourning process. It is one step toward accepting and compensating for loss. It is important to feel grief and not suppress it; prolonged depression can alter the immune system and increase the risk of illness.

The stages of grief differ from person to person, just as the manner in which grief is expressed is variable and unpredictable. The critical period, however, is usually the first six months after the significant loss. Shock, physical changes, depression, and idealization are all common reactions to loss, as are feelings of guilt and anger. Although the loss and accompanying grief may always be felt, acceptance, adjustment, and the development of new patterns are essential in order to get on with living.

Denial is a defense against the pain of loss that is expressed by a refusal to acknowledge loss. It is one of the most powerful mental defense mechanisms. Denial can be very useful in helping the elderly to recover their emotional balance. However, denial can also seriously interfere with daily functioning.

Grieving is rarely smooth and ups and downs are common, even after months or years. Family and friends should be aware of some of some of the specific needs of the grieving individual. First, the individual needs to come to terms with the loss and, second, needs support and companionship. Third, the individual needs to mourn the loss and, lastly, needs to rearrange his or her life; resolve the loss, make adjustments, and go on.

The majority of older people do absorb numerous losses, compensate, and carry on. However, for those individuals who are unable to adapt, unsuccessful grieving may result in diminished life satisfaction and prolonged suffering. Unresolved losses can not only reduce enjoyment of life, but can shorten life as well.

The most reliable safeguard against these unwanted effects is to ensure that the individual works through the losses and begins filling in the voids with new interests, goals, and relationships.

If you or anyone you know is suffering from loss or grief, contact your nearest Montana Community Mental Health Care Center.

Thirty-four mental health care centers are located throughout Montana.

GOOD MENTAL HEALTH FOR ELDERLY MONTANANS-ELDER ABUSE

Since 1975, the trend in meeting increased needs of the elderly in this country has been toward provision of in-home care services. The goal has become to keep the aging person in a family or independent situation. However, in-home care often imposes intolerable financial, physical, and emotional burdens. In spite of a strong commitment to in-home care, a combination of stresses may increase the risk of domestic mistreatment in the form of abuse, neglect, and exploitation of the elderly.

Neglect can occur in several forms: passive, active, or self. Ignorance of existing services and isolation are common to all forms. Passive neglect is the inability to fulfill a caretaking obligation due to a variety of stress-related factors. There is no conscious or willful attempt to inflict physical or emotional distress on the older person. The physical, emotional, and financial demands of in-home care may be more of a burden than many people can handle. One or two adults may try to carry on the same functions as performed by the entire staff of a home for the aged. Often, family members are too busy or preoccupied to pay any attention to the elderly. As a result, isolation and the feeling of being unwanted follow.

Active neglect involves the intentional failure to fulfill a caretaking obligation. Some examples are the deliberate withholding of services, materials, or intangibles such as contact

with friends. Again, the neglect is related to a combination of stress elements in the caregiving situation. Both passive and active neglect can occur only when the victim is dependent upon the caregiver.

Self neglect has only recently been recognized as another form of elder abuse. "Self abuse" is typically the negligent and potentially life-threatening actions of a mentally deteriorating older persons who live alone and are unable to care for themselves adequately, but who resist outside help. On occasion, the self-neglecting individual is a competent person who fails to conform to community standards of conduct, hygiene, or maintenance of home or property.

Psychological abuse involves active intent on the part of the caregiver to inflict mental anguish. It is not necessarily associated with a dependent-caregiver relationship. In fact, some abusers may be dependent on their victims. Some examples of this type are demeaning, name calling, treating as a child, frightening, humiliating, threatening, and isolating. Such misbehavior is generally associated with a poor relationship between the victim and the abuser. The extent of abuse many be exacerbated by emotional crises such as unemployment, divorce, and alcohol abuse. Psychological abuse can produce serious problems for the victim, among them depression, isolation, reduced self esteem, and self-destructive tendencies. It is quite possible for the victim of such abuse to be fully independent.

Financial abuse is the illegal or unethical exploitation and/or use of funds, property, or other assets belonging to an older person. These are forms of theft, but are rarely reported or prosecuted by relatives or friends for fear of retaliation or loss of the only support system they know.

Physical abuse is the most commonly discussed kind of abuse, but occurs least often. It involves the inflicting of physical pain or injury, or physical coercion. Alcohol abuse by the victim or the perpetrator, or both, is often associated. It also occurs in combination with neglect and psychological abuse. Instances of physical abuse rarely come to the attention of the medical or criminal justice systems. This is particularly true of the elderly since society's sensitivity to and awareness of mistreatment of the elderly is so low.

Older men who are widowers are more at risk than widows. Women seem better able to cope with meeting their own needs. However, the overall incidence rate nationwide and in Montana shows that more women are victims than men, which is proportionate with the demographics of the elderly since women live longer. Lower-middle-income families are vulnerable due to lack of money and lack of an extended family as a buffer. Rural populations may be higher risk due to the scarcity of support networks and isolation. Lack of transportation and telephone service in lower income populations also increase risk.

As mentioned before, in all categories of mistreatment there exists a motivation to cause harm, either active or passive intent, and a duration that may exceed several years. A current theory that may apply in some cases is called the "Cycle of Violence." In these cases, the abuser may have been abused by the victim when a child or suffered abuse during his or her youth. Recognition of stress factors is an important consideration in seeking causes for abuse. Many combinations of life circumstances may add up to an abusive response by the perpetrator. Examples include alcohol and substance abuse, losing a job, divorce, and health problems. Social isolation is another factor. Early recognition of risk factors that lead to abusive interactions are important for public awareness so that timely intervention is possible and effective.

The most positive intervention is a change in the living and social situation. The biggest barrier can be refusal of the elderly person to accept help. There is a great need for increased education and training about the multiple aspects of elder abuse. In the future, more information that will become available through research can provide additional insight into the consequences of abusive acts, and thus be helpful in planning prevention and treatment programs.

If you are being abused, or know of someone whom you suspect is being abused, contact your nearest Montana Community Mental Health Care Center.

GOOD MENTAL HEALTH FOR OLDER MONTANANS-NATIVE AMERICAN ELDERLY

The culture in which we live defines most things in our lives. Certainly, this holds true for aging. Culture dictates the "value" or lack of value in being aged. The culture decides who should care for the elderly and how long life should be prolonged. Although all of these factors are found in any culture, minority cultures such as Native Americans experience additional pressures from outside forces. When a minority culture confronts a dominant culture, the basic beliefs and premises of the minority are tested.

Native Americans traditionally respect their elders and look to them for knowledge and guidance. Status is related to the degree of control over valued information. In modern society, with the rapid pace of change in technology and the workplace, the young have the edge in training and education. Knowledge of the old ways is less and less valued.

In 1980, a mini-conference on American Indian and Alaskan Native Elderly was held as part of the White House Conference on Aging. The mini-conference report includes a review of the economic and social conditions of these groups. Poverty is pervasive: the median income (1970) for males over 65 was $1540, as compared with $5327 for the total population. Most elderly Native Americans do only seasonal or non-recorded work during their lives. Only approximately 45% have any Supplemental Security Income or Social Security benefits. Tribal money, on-reservation, may reduce other benefits, leaving the elder with less than before.

The average life expectancy among Indian peoples is 65, while it is 75 for non-Indians. The average Indian barely survives to entitlement age.

There is a great need for adequate housing and additional assistance for fuel, food, and medical care. Health problems, as indicated by the lower life expectancy, are more prevalent among Indian elderly than their non-Indian counterparts. Higher rates of tuberculosis and diabetes exist among Native Americans. The rate of tuberculosis is five times higher than the rate for non-Indian elderly. More obesity may explain the higher rate of heart disease. Alcoholism may compound the health problems. It also affects the elder through the younger generation which demands money to buy alcohol, leaving the older person without money for food and basic needs. This vulnerability to exploitation is compounded by the cultural ethic of sharing and giving as proscribed social values.

In the mental health area, many suffer from neuroses such as anxiety or depression. However, Indians receive services less often than non-Indians. Mental health diagnostic instruments sensitive to cultural differences are lacking, as are trained Indian mental health practitioners.

Traditionally, elders were respected and valued as repositories of wisdom and experience, honored as teachers of tribal culture and history. In modern society, less respect is

accorded and the extended family is broken. Still, the family continues to be the major source of services and support, particularly in rural environments. The mini-conference also suggested that enhancement of family care and support would be welcomed by the Indian community as a way to strengthen traditional values.

According to Steve Williamson, director of the Area Agency on Aging office which works with six of the seven reservations in Montana, there is an overall lack of basic information regarding the needs of Native Americans and a gap in the referral system. Elderly are often exploited by younger generations, partially because of the extended family care of the elders and their inability to say "no," which is culturally instilled. Overall, nursing homes are avoided. Only one nursing home exists on a Montana reservation, in Browning on the Blackfoot Reservation. No intermediate care facilities are located on-reservation. Most care occurs in-home or in congregate housing facilities. Congregate housing allows elders their own housing, with communal meals served once a day. Many elderly avoid such housing, preferring greater independence.

The on-reservation healthcare needs are met through the Indian Health Service. This federally funded program serves the population of Indian decent. The IHS provides mental health services through on-reservation facilities, either clinic or hospital, or through contracted services with the regional

Community Mental Health Center. If the CMHC has any specialized treatment programs, such as those for sex offenders or alcoholism, the IHS might refer clients there. A gap in services can occur when a Native American person moves off-reservation. The eligibility for treatment through IHS is maintained for 90 days. After that time, the client is no longer eligible for such contracted services as mental healthcare through the CMHC. Often, elderly Native Americans dwelling in urban areas lack medicaid coverage due to difficulty with the application process. They may be reluctant to go directly to a non-Indian-based service. Therefore, the person may not receive diagnosis or treatment of a mental health problem.

Meeting basic housing, utilities, and transportation needs is a pressing concern for most Native American elderly in Montana. Since the elderly still frequently reside with their extended families, the problem of exploitation continues. Currently, only two reservations have stated law that addresses this problem. Overall, it seems that, if the already existing family care support structure could be enhanced, conditions for the elders would improve. Further expansion of health services to provide adequate housing and nursing facilities would also improve the situation for the Indian elderly.

GOOD MENTAL HEALTH FOR OLDER MONTANANS-THE MONTANA NETWORK OF MENTAL HEALTH SERVICES

The Montana mental health network has a core of institutions plus community-based mental health centers and their 26 satellites located throughout the State. These facilities work in conjunction with the courts, other State agencies such as Family Protective Services, and the federally funded Indian Health Service.

"The Department of Institutions is the designated mental health authority for the State of Montana. Title 53, Chapter 21, MCA; and Part B, Title XIX of the Public Health Services Act define the state and federal mental health laws and authorize funding for the development of comprehensive mental health services. The Department of Institutions is required by this law to prepare and maintain a comprehensive plan for public mental health service. The Montana Mental Health Plan is a public document intended to guide and coordinate these services."

Thusly commences the Montana Comprehensive Mental Health Plan: Fiscal Years 1988-1989. This plan describes the process of change and how the system is committed to responsiveness toward meeting the current needs of the population. The plan is designed to help determine priorities for myriad changing needs and to maintain consistency with state and federal priorities. Within the Department of Institutions, the Treatment Services Division has been delegated responsibility for planning, organizing, and directing the State's mental health programs. This Division has

two Bureaus: the Chemical Dependency Bureau and the Mental Health Bureau. The Mental Health Bureau provides administrative supervision and coordination for institutional and community programs for the mentally ill, institutional programs for the developmentally disabled, and residential nursing homes for veterans and elderly persons with chronic mental disorders.

The Department of Institutions is mandated to meet the mental health needs of the public through a variety of avenues, including preventive mental health activities of the statewide mental health programs through community-centered services. A commitment to public education and dissemination of pertinent information relating to mental health issues exists. Additionally, they provide examination at a person's request or, through the Montana State Hospital or other public mental health facilities, establish standards for these facilities and ensure that performance complies with federal and State standards. Federal law requires establishing a State advisory council on mental health.

Two State mental health institutions are operated directly by the Department of Institutions: the Montana State Hospital and the Montana Center for the Aged. The Montana State Hospital consists of campuses at Warm Springs and Galen. Warm Springs is the adult state mental health facility which provides inpatient psychiatric treatment for seriously mentally ill adult Montanans. Galen provides residential treatment for persons suffering from chemical dependency, acute medical hospital care for patients from both

Montana State Hospital campuses, and intermediate nursing care for mentally ill individuals who require nursing services.

The Montana Center for the Aged is located in central Montana at Lewistown. This center is a licensed longterm care facility for treatment of persons 55 and older who have chronic mental disorders associated with the aging process and who cannot benefit from intensive psychiatric treatment available at the Montana State Hospital.

The Department of Institutions also provides for community-based services by contracting with non-profit mental health agencies throughout the State. The Bureau determines the level of services to be purchased based on assessed need from each region, priorities set in the mental health plan, and the capacity of the agency to provide such services. The Montana community mental health system is comprised of a variety of local agencies as well as independent private practitioners and short- term psychiatric inpatient units. Virtually all of the Department's community mental health funds are used to purchase services from five regional Mental Health Centers.

The Montana Mental Health Centers are private, non-profit organizations designed to provide high quality mental health care to Montana citizens. They are financially sustained through various sources: client fees, county contributions, businesses and agencies, contracts with state and federal authorities, and

private donations. Their staff of trained professionals includes psychologists, psychiatrists, psychiatric social workers, and psychiatric nurses.

The MHCs not only provide clinical services to people with emotional and behavioral problems, but they offer assistance in other areas as well. Their promotion of mental health through educational programs assists individuals in acquiring knowledge, attitudes, and behavior patterns that foster their mental well being. The Centers also provide consultation to professionals such as physicians, nurses, and law enforcement officials in order to expand and enhance their helping skills.

Fees for services provided by the Mental Health Centers are based on an individual's ability to pay. Insurance companies, Medicare, Medicaid, the Veterans Administration, and other government agencies are billed as appropriate.

Five Mental Health Centers are located in Montana, each serving a multicounty region. Headquarters are located in Billings, Great Falls, Helena, Miles City, and Missoula. Individual counties, by law, are not required to participate in the regional Mental Health Centers. However, this discretion may result in funding instability for the Mental Health Centers, inequities in financial commitment across counties, and inequities in accessibility of services for those in need. Even though Mental Health Centers do not provide services in non-participating

counties, residents of those counties can continue to be served in the mental health system on a non-discriminatory basis. Presently, four counties do not participate in the system due to budget and/or other considerations: Carter, Powell, Gallatin, and Choteau.

Mental health needs of Montana's elderly population are met primarily through the five Mental Health Centers contracting with the Department of Institutions. A gap in services to the elderly does exist with respect to those residents of longterm and intermediate care facilities that are private or community-based nursing homes. There seems to be a lack of interaction, funding, and ability to meet the needs of this population. Doug Blakely, the State longterm care ombudsman, reports that there are two main problems inhibit provision of mental health services to elderly in nursing homes: the unavailability of trained persons to care for the problems and limitations in the nature of the facilities -- they must control troublesome behavior and are predisposed to using sedation and restraint.

Referrals to the core system of mental health care come from a variety of sources. Family Protective Services receives referrals from the public concerning possible instances of elder abuse. Possible intervention might include use of mental health services through the CMHCs. Often, a representative of the CMHC is part of an intervention team. The Indian Health Service also makes referrals in behalf of the Native American population. Referrals also come from the Area Agency on Aging which has

Information and Referral Technicians in almost every county in Montana. A toll-free number for the Governor's Citizen's Advocate is also available. This number can potentially connect the older person with the Longterm Care Ombudsman or Adult Protective Services.

The challenge facing Montana to adequately meet the increasing needs of our elderly requires creative network building and allocation of available funds which emphasize community-based mental health services rather than service in institutional settings.

GOOD MENTAL HEALTH FOR OLDER MONTANANS-SUICIDE AMONG THE ELDERLY

Suicide is one of the 10 leading causes of death in the United States, with the highest rate of suicide among older persons. In the overall population, the incidence increases with age and peaks around age 75. The rate is an estimate, not actual, because many suicides go undetected and some are concealed. Accidents, especially those involving motor vehicles, overdoses of prescribed medication, or the long-term self neglect associated with alcoholism can mask deliberate self destruction.

There is a gender-linked difference. For women, 12 out of 100,000, the rate peaks between 50-54. For men, 50 out of 100,000, it increases steadily until age 85. Suicide is a more frequent cause of death among the elderly than among any other age group. This is due primarily to the relatively high suicide rate among older white men. In the total population over 50, the suicide rate is 37%. The white population accounts for 28% of the total reported suicides. In 1984, the suicide rate for white men 65 years and older was nearly four times the national rate, three times the rate for older black men, six times the rate for older white women, and 24 times the rate for older black women. The rate of attempted to actual suicides shifts dramatically for older persons. For those over 55, it is 1:1, as compared to ages 15-24 where it is 100:1 and for the overall population, 10:1.

Some possible causes or predispositions toward suicide include disruptions in social relationships or social isolation. Social

isolation has been re-termed social desolation as a more critical distress factor. Some predisposing factors are physical illness, lack of employment and impoverishment, and bereavement. Cultural differences must be taken into account; one cannot simply apply the norms. Vulnerable groups include widows and widowers, especially widowers. Statistics show a high rate of death among these groups within one year after the death of a spouse.

A diagnosis of depression is only preliminary to determining risk. Approximately 50% of older individuals who kill themselves do not exhibit the clinical features of depression. There is an emphasis on one aspect of depressive symptoms, that of 'negative expectations of the future.' The capacity to successfully deal with aging depends on finding meaning and personal satisfaction. The psychosocial aspect is more important than aging in general. The loss of mastery, prestige, and power may be factors in the rate of older white male suicide. A very high-risk population includes persons who have experienced significant loss and who abuse alcohol.

Physicians play a crucial role in risk assessment of potentially suicidal persons. Over 75% of the elderly who commit suicide see a physician shortly beforehand. Three major factors have been identified as contributing to suicide among the elderly: haplessness, helplessness, and hopelessness. Lowered self concept and self esteem contribute to a sense of haplessness among the elderly. Persons who are unable to influence significant life

events may develop a sense of helplessness. Helplessness and hopelessness often go hand and hand.

Several kinds of clues can be used to identify at-risk persons. These may be either direct or indirect. These clues are classified as verbal, behavioral, situational, or syndromatic. Direct verbal clues include statements such as, "I'm going to kill myself" or "I'm going to end it all." Indirect statements might be, " I'm tired of life", " My family would be better off without me," or "Who cares if I'm dead anyway?"

The most direct behavioral clue, of course, is the suicide attempt. Indirect clues include donating one's body to a medical school; purchasing a gun; stockpiling pills; making funeral plans; giving away money and possessions; changes in behavior, especially episodes of hitting and screaming, or throwing things; and suspicious behavior such as going out at odd times of the day or night.

In some cases, the actual situation itself can be a clue to contemplation of suicide by the elderly. A recent move, death of a spouse or a child, or friend, or diagnosis of a terminal illness may precipitate a suicidal crisis. Recent arguments with family members or significant others may signal danger. Depression, particularly when accompanied by anxiety, is the most important clue to suicide. Tension, agitation, guilt, and dependency are other important syndromatic clues.

Any older person showing several of the above clues should be considered a suicide risk. Appropriate supportive interventions should be initiated. Suicidal statements, and any sign of helplessness, should elicit an intervening response. Some examples are demonstrations of genuine concern, interest, and caring; companionship; indications of empathy for their concerns and fears; and helping to formulate a plan of action to resolve the precipitating situation.

It is a mistake to believe that little can be done in intervention with elderly suicidals. For the immediate caregiver or physician, three steps of questioning are recommended: ascertain whether there is an actual suicide plan; determine the availability, accessibility, and lethality of the plan; and ask direct questions such as "How is your life going?" By listening to the responses, the range in terms of lethality potential can be determined. For example,the admission of intent is a high lethality potential.

A combination of counseling, both individual and group, plus anti-depressant medication, might follow the immediate intervention. If risk is determined as very high, the person may have to be hospitalized or placed under close family supervision. It is recommended that coping mechanisms be left intact. The task is to identify the maladaptive strategies and try to encourage replacement with a more positive adaptive strategy.

No discussion of suicide is complete without reference to the survivors. It has been said that in successful suicide there are two victims: the dead person and the survivors. Until recently, social stigma prevented the survivors from receiving recognition and therapy for their distress. Instead, they were often branded through the media and left isolated with guilt and remorse. Fortunately, more publicity and education concerning the unanswered questions of suicide and its victims has allowed survivors to seek support and therapy. It also opens up the possibility of recognition and successful intervention. There is much work to be done on this problem in Montana.

GOOD MENTAL HEALTH FOR OLDER MONTANANS-ALZHEIMERS DISEASE

Alzheimers disease is a progressive, degenerative disease that attacks the brain and results in impaired memory, thinking, and behavior. Although less than one percent of people age 65 are affected by Alzheimers, it is present in an estimated 25% of those age 85 or older. Alzheimers has been cited as the fourth largest killer of American adults and the most frequent cause of institutionalization of the aged in long-term care facilities. In 1987, approximately 12% of the older adult mental health cases treated by the Montana Community Mental Health Care Centers were diagnosed as Alzheimers disease or some other form of organic dementia.

Alzheimers is the most common form of dementia, a non-specific clinical syndrome characterized by global deterioration of intellect, cognition, behavior, and emotions without impairment of consciousness. Dementia is not a disease, but a group of symptoms that characterize certain diseases and conditions. Alzheimers accounts for 50 to 70% of dementia cases, with an estimated 2.5 million Americans afflicted with the disease.

The onset of Alzheimers is usually slow and gradual. At first, the symptoms are minor and almost imperceptible, often erroneously attributed to physical illnesses or emotional upsets. Over time, however, the person becomes more forgetful, particularly about recent events. Memory loss increases and other changes, such

as confusion, irritability, restlessness, and agitation, are likely to appear in personality, mood, and behavior. It is important to realize that memory loss that interferes with everyday living is NOT NORMAL even in advanced old age. Although identifiable patterns exist as to the progression of Alzheimers, the disease varies from person to person. In the most severe stage, the disease eventually renders its victims incapable of caring for themselves.

Other conditions can mimic Alzheimers at its various stages. Among them are depression, drug reactions, brain tumors, alcoholism, stroke, and infections such as meningitis, syphilis, or AIDS. It is essential that suspicious changes in physiological or psychological activity be thoroughly evaluated before they become inappropriately or negligently labeled Alzheimers disease. Accurate diagnosis involves a process of elimination; other possible disorders must be ruled out before a diagnosis of Alzheimers can be made. Moreover, the only definitive way to confirm a diagnosis of Alzheimers is to examine brain tissue under a microscope.

Although the cause of Alzheimers is not known, research is focused in several areas. In samples taken from biopsies of Alzheimers victims, it is often found that an enzyme needed to manufacture acetylcholine, an important neurotransmitter, is in short supply. Another theory regarding causality involves environmental toxins; aluminum has been found in large amounts in

the brains of some Alzheimers patients. Some researchers cite genetic factors as a possible cause, that is, in order for the disease to develop, genes must interact with environmental factors.

The person afflicted with Alzheimers is not the only victim of the disease since his or her caregivers suffer as well. During the early phases of Alzheimers, a person can most often be cared for at home. In its later stages, full-time professional care may be required. The emotional, social, and financial strain that families often experience in trying to cope with the disease may cause feelings of anger, frustration, guilt, and sorrow. Emotional support and understanding from family, friends, and/or a mental health professional can be a key ingredient in adjustment to the illness and the demands it makes on patients and their caregivers.

Further research on Alzheimers is needed to provide answers that can lead to treatments and/or strategies for prevention of the disease. In the meantime, however, proper medical care for the patient can reduce many of the symptoms of Alzheimers. Sound guidance can assist the person and family in dealing with the significant impact imposed on their lives by the disease.

If someone you know is, or appears to be, suffering from symptoms of this crippling disease, contact your nearest Montana Community Mental Health Care Center.

GOOD MENTAL HEALTH FOR OLDER MONTANANS-DEMENTIA, A CASE OF CONFUSION

Dementia affects an estimated 5% of the population 65 years of age and older, with 20% of these 75 years or older affected. Dementia is a non-specific clinical syndrome characterized by global deterioration of intellect, cognition, behavior, and emotions without impairment of consciousness. Diagnosis involves ruling out all other possible causes.

Distinguishing between delirium, false delirium, and dementia is difficult. Delirium has a physical cause. Onset is rapid and it is a short-term acute brain syndrome. The physical cause must be determined or death will result. One form of delirium occurs in the late stages of alcoholism. Depression is misdiagnosed as dementia so frequently that it is referred to as "pseudodementia." When patients remember they forgot something, that can be considered forgetfulness rather than dementia.

The two most common forms of dementia are Alzheimers disease and multi-infarct dementia, commonly known as "hardening of the arteries." Alzheimers accounts for 50-70% of all cases, while multi-infarct accounts for 20-30% of dential diagnoses. Other forms are Parkinsons, Huntingtons, Picks, and Creutz-Jacob diseases. Although most common forms lack specific treatments, it is estimated that 10-20% of those diagnosed with dementia might have a treatable cause. Differential diagnoses include benign forgetfulness, depression, adjustment disorder, paranoid states,

amnesia, delirium, drug effects, systemic illness, and intracranial conditions. When no specific treatments are available, however, symptomatic treatments, including psychotherapy, can provide relief for patients and their families.

Theories regarding the causes of dementia range from genetic to viral sources and environmental toxins. At present, there is no conclusive evidence for any of the theoretical causes. Some evidence suggests that forms such as Alzheimers and Huntingtons may involve genetic predisposition. Another theory is based on abnormal protein models where affected cells send a signal to the immune system. The side effects of extensive immune action may themselves produce damage to surrounding cells. In the toxin model, evidence has shown higher than normal amounts of aluminum in dementia victims.

Even after arriving at an accurate diagnosis specific treatment of the underlying cause may not reverse the cognitive deficit completely. However, it may arrest the dementing process by alleviating associated symptoms. Treating older patients may have complicating factors since treatment of one illness often affects other concurrent conditions. Even minor medical illness may upset a delicately maintained intellectual integrity, but comfort and daily functioning of patients can be improved through symptomatic treatment. These include pharmacological treatments, environmental management, family support, and psychotherapy.

Pharmacotherapy treats sleeplessness, agitation and paranoid symptoms, and depression. A controversial approach uses psychostimulants to alleviate apathy and withdrawal symptoms.

Environmental management responds to the sensitivity of intellectually impaired elderly to their surroundings. Demented patients do best in familiar and constant surroundings. Daily routines enhance their sense of security. Prominent displays of clocks and calendars, night lights, checklists, and diaries all aid in orientation and memory. Medication schedules must be kept as simple as possible. Moves should be avoided, but, when necessary, photographs and other familiar objects should be placed nearby. Frequent family visits and access to current events help maintain patients' awareness of their environment.

Family support through counseling and education encourages family involvement in patients' treatment. The patients' loss of inhibitions, emotional and verbal, as well as physical incontinence, may cause the family embarrassment. Additionally, the accumulative stress from dealing with caregiving and finances may result in family difficulties. Support groups may facilitate the family's ability to cope with the extended duration of the disease. Both the patient and family may benefit from psychotherapy. Patients often need help in grieving and accepting their disability. Psychological support for caretaking persons will lighten their emotional burden. Anger, guilt, frustration, and helplessness are all normal responses to the task of caring for

a once vital, but now deteriorating loved one.

Treatment must be directed at long-range management rather than cure. Recently, some innovative approaches have emerged. Adult daycare programs serve as an alternative supplement that enables family caregivers to continue working while the impaired elder remains in a home environment for a longer period of time. Early diagnosis enables the development of a clear plan for care, existing drug treatment can be rationalized and appropriate treatment started at a stage where it will be most beneficial.

GOOD MENTAL HEALTH FOR OLDER MONTANANS-SUBSTANCE MISUSE AND ABUSE BY THE ELDERLY

Persons 65 and older consume 33% of all prescription medication. Figures from the Federal Drug Administration show that, although the population over 65 is only 17% of the total population, this group accounts for over 50% of deaths from adverse drug reactions. Thirty-nine percent of hospitalizations from adverse drug reactions are attributed to this group. Many chronic conditions in persons over 65 require medication.

Since 1976, the FDA has approved over 1000 new drugs, and 10,000 drugs are currently available on the market. Recently, the Senate Special Committee on Aging convened a study of this problem as it relates to the elderly. This hearing found that education for physicians and other healthcare providers is not keeping abreast of advances in pharmaceuticals. There is also a general lack of geriatric training. Additionally, since educational materials are often produced by pharmaceutical companies, not much input has come from non-commercial concerns that do not profit from sale of these products.

Misuse of medication often occurs unintentionally. Most substance misuse is accidental. An individual may take the medication at the wrong time, in the wrong quantity, or in the wrong form. An example would be the crushing of a pill meant to be absorbed over a long period of time or taking it with the wrong foods. Other common misuses include mixing medication with alcohol

and taking old medication. Caregivers may also make such errors.

Abuse, by definition, is intentional. Instances of abuse include making a decision to stop taking a life-sustaining drug or a prescribed medication without consulting the physician and stockpiling anti-depressants or sleeping pills for use in a self-destructive manner. Caregivers might intentionally withhold medication or give the wrong dosage.

Physicians may react to the elderly patient with an ageism bias. This attitude allows physicians to ignore the addictive substances problem with the elderly by justifying that it is alright for the elderly to become addicted because of the need for relief from pain. One such bias assumes that aging is a crippling and helplessness producing syndrome. The elderly patient may fall into a pattern of dependency and avoidance of confrontation with a physician through the self-administration of medication. The initial attraction to drugs for physical and psychiatric reasons can yield to dependency and problems of loneliness, boredom, and depression. Most often-prescribed drugs include Valium, Librium, non-narcotics, and analgesic Darvon.

Jim Mount, a psychologist with the Miles City Community Mental Health Center, offers the following advice for older persons regarding the taking of medicine: "Put your glasses on and do not take them in the dark."

If an adverse reaction to drugs occurs, begin by examining the most recently prescribed drugs first. If appropriate, try waiting to see if the adverse symptoms abate. If the problems are serious or troublesome, report them to a physician. Education is the key to changing our relationship with prescription and non-prescription substance misuse. Forming a partnership with your physician and becoming aware of possible preventative actions will reduce the possibility of adverse drug reactions due to misuse.

GOOD MENTAL HEALTH FOR ELDERLY MONTANANS-INTERGENERATIONAL RELATIONS

It is often said that our culture determines the way we are thought about, evaluated, and treated on the basis of age. Ageism is defined as aversion, hatred, and prejudice toward the aged and their discriminating manifestations. It has come to be known as the third -ism along with racism and sexism. This attitude and behavior prevent elderly individuals in our society from attaining their fullest potential and deprives us all of a valuable national resource.

An ageist society makes harsh decisions and evaluations about people in later stages of life. For example, mandatory retirement practices deprive persons and groups of the right to control their own destiny. This results in social and economic discrimination and deprivation. It deprives our society of contributions by many competent and creative persons needed to deal with our vast and complex problems. Finally, it results in alienation, despair, and hostility.

Young and old alike are affected. Ageism allows judgment of one's abilities based on chronological age. In a society, ageism may be reinforced by changing technology, industrialization, changing family patterns, increased mobility, increased life expectancy, and increased generational differences. Our society encourages and reinforces the high value of productivity. Changes in technology and industry tend to make skills and knowledge

rapidly obsolete. Consequently, older workers are replaced by younger, faster, recently trained workers.

Forms of ageism in our society include the following:

Overt Ageism: Instances of this, such as derogatory names or outright insults to older persons, are relatively rare. Ageism will most likely be more subtly expressed.

Pepsi Generation: The preoccupation and infatuation with youth in our society, especially in advertising: youth is good and, conversely, "old is bad."

Absence Ageism: Ageism is often manifested by an absence of positive images. This occurs not only in print and television imagery, but also in childrens' books which rarely portray anyone other than childrens' parents and peers.

Categorizing: Old people are often stereotyped as a class or group, especially in academic and agency circles. Such classifying can lead to a depersonalized portrayal of individuals as anonymous members of an abstract class.

Paternalism: This may occur when adult children start deciding things "FOR" their parents without consideration for their parents' opinions.

Weakness: Certain physical and mental weaknesses eventually accompany old age. When these are exaggerated or exploited, they become instances of ageism. This can happen in advertising, assumptions made by insurance companies, and decisions from courts regarding personal injury.

Denial and fear of aging are results of these subtle patterns of ageism. Young people believe that they will never grow old. Denial causes avoidance of any allusion to the aging process. The media reinforce the negative stereotypes, such as aging is ugly and bothersome, or by implying that the elderly are sluggish and preoccupied with irregularity and constipation.

One of the most obvious examples of ageism in our society is federal legislation concerning mandatory retirement. The age of 65 is arbitrarily regarded as the onset of old age. This view is reinforced by the 1935 Social Security laws. In 1978, federal legislation raised the upper age limit for retirement coverage to 70 in an amendment to the Age Discrimination in Employment Act. This facilitates voluntary retirement. There is considerable medical evidence that mandatory retirement may have a detrimental effect on physical, emotional, and psychological health. Older persons need to be regarded as a valuable national resource and should be extended full rights as individuals to make their own choices regarding work and retirement.

Appendix J: Informational Brochure

Americans age 65 and older are the fastest growing sector of the population and the most vulnerable to major mental health problems. It is estimated that 15 to 20 percent of the elderly suffer from some form of mental illness. Early recognition and intervention may prevent a temporary impairment from becoming a permanent disability.

For information or assistance call the mental health center nearest you.

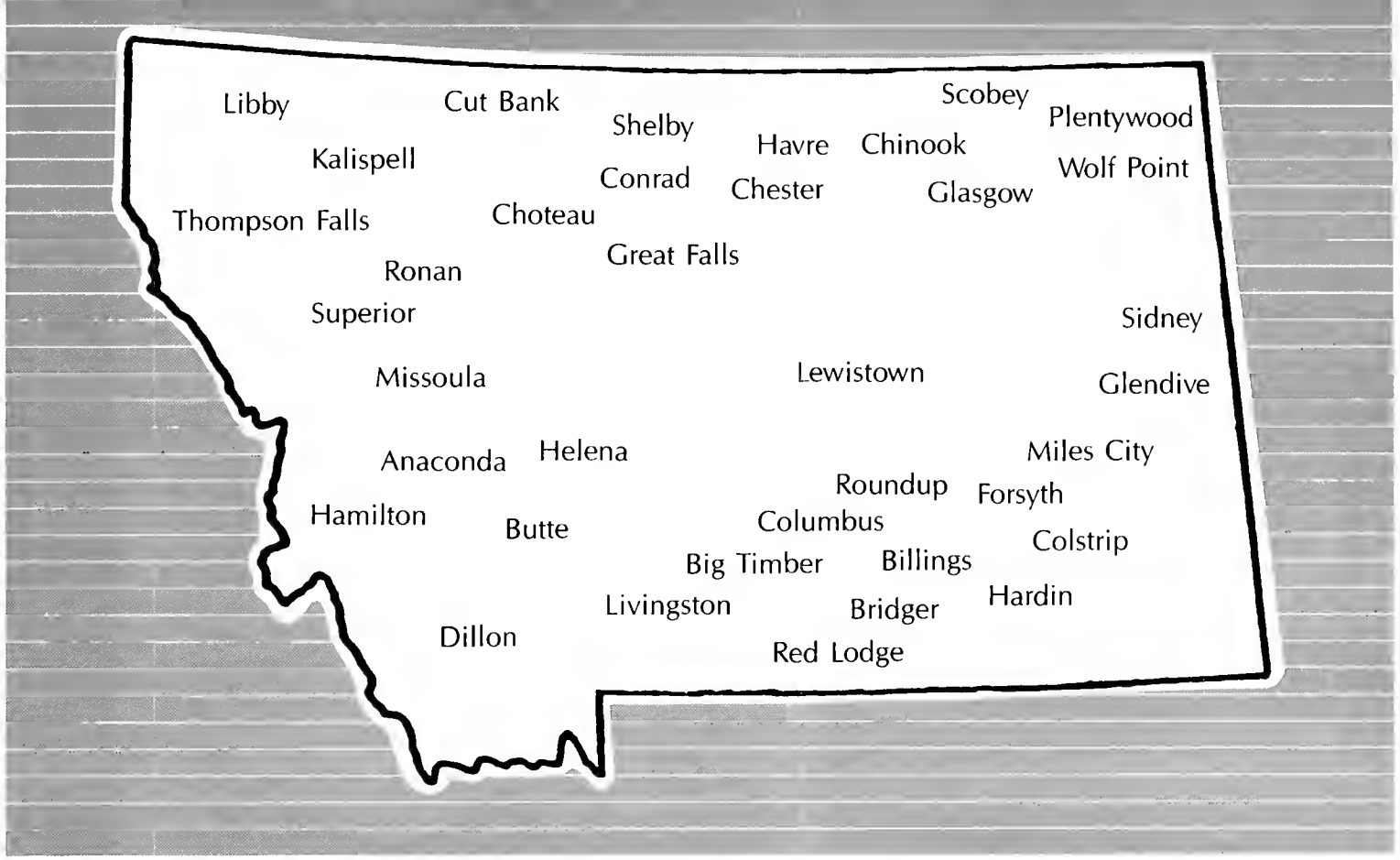
Anaconda	563-3413
Big Timber	932-5924
Billings	252-5658
Bridger	662-3469
Butte	723-5489
Chester	759-5410
Chinook	357-3364
Choteau	466-5681
Colstrip	748-2800
Columbus	322-4514
Conrad	278-3205
Cut Bank	873-5538
Dillon	683-2200
Forsyth	356-7654
Glasgow	228-9349
Glendive	365-6075
Great Falls	761-2100
Hamilton	363-1051
Hardin	665-1049
Havre	265-9639
Helena	442-0640
Kalispell	752-6262
Lewistown	538-7483
Libby	293-6513
Livingston	222-3332
Miles City	232-1687
Missoula	728-6817
Plentywood	765-2550
Red Lodge	446-2500
Ronan	676-8500
Roundup	323-1142
Scobey	487-5442
Shelby	434-5285
Superior	822-4093
Sidney	482-4635
Thompson Falls	827-4377
Wolf Point	653-1872

Sponsored by:
Administration on Aging,
Department of Health and Human Services
Montana Area Health Education Center
Montana State University
Montana Center of Gerontology
Montana State University
Aging Services Bureau
Montana Department of Family Services
Montana's Community Mental Health Centers

Mental health problems are not a normal part of aging.

The Montana Mental Health Network may be able to help.

The Montana Mental Health Network



The Montana Mental Health Centers are private, non-profit organizations designed to provide high quality mental health care to to Montana's citizens. Their staff of professionals includes psychologists, physicians, therapists, counselors, and other experts who are specially trained to help people of all ages deal with life's problems.

Some problems for which older adults seek help at Montana's Community Health Centers include:

- Depression
- Anxiety
- Moodiness
- Alcoholism
- Drug abuse other than alcohol
- Social peers, withdrawal and other social problems
- Delirium
- Emotional Disturbances
- Delusions
- Uncontrolled, compulsive and impulsive behavior
- Alzheimer's disease
- Personality disorders
- Amnesia
- Irritability and temper
- Hallucinations
- Family problems
- Uncontrolled aggression
- Sexual problems
- Stress
- Marital problems

Services commonly provided:

- Diagnosis and evaluation
- Counseling: Individual, group, marital, and family therapy
- Case management: treatment planning, coordination, patient advocacy, and care monitoring
- Community consultation services and education
- 24-Hour emergency service and crisis intervention
- Day treatment: Day-long treatment, including counseling, therapy, leisure and recreation skills, socialization, and daily living skills

Appendix K: Statewide Conference, "Improving Mental Health Care Services to Montana Elders: New Strategies and Solutions to Enduring Problems"

MONTANA
HEALTH
EDUCATION
CENTER

Culbertson Hall, Room 308
Montana State University
Bozeman, MT 59717
(406) 994-6001 Fax (406) 994-6993

We are pleased to invite you to participate...

In a working conference on mental health and the elderly:

IMPROVING MENTAL HEALTH CARE SERVICES TO MONTANA'S ELDERLY:
NEW STRATEGIES AND SOLUTIONS TO ENDURING PROBLEMS

The conference will focus on the mental health care problems of older adults including qualitative and quantitative deficiencies, and will develop preliminary strategies that can be implemented to reduce these problems.

The day-long conference will be presented from 8:30 a.m. to 5:00 p.m. on Friday, November 18, 1988, Colonial Inn, State Capitol Room, Helena.

There will be a $10 registration fee for the conference which will cover the buffet lunch and coffee breaks. The $10 fee will be collected during registration the morning of the conference. If you do no want to participate in the lunch and coffee breaks, no registration fee is required.

The conference is sponsored through a grant awarded by the Administration on Aging to the Montana Department of Family Services and contracted to the Mental Health Center in Billings, with assistance from the community mental health centers in Missoula, Helena, Great Falls, and Miles City.

For further information, you may contact:

Jim Mount, Eastern MT Community MHC, Miles City; 232-1687
Sharon Harris, South Central Community MHC, Billings; 252-5758
Linda Hatch, Golden triangle Community MHC, Great Falls; 761-2100
Sue Bennett, Mental Health Services, Inc., Butte; 723-5489
David Washburn, Western MT Community MHC, Missoula; 728-6817
Gary Refsland, Montana Center of Gerontology, Bozeman; 994-6001

Please complete the enclosed pre-registration form and return it by November 11, 1988, to the Montana Area Health Education Center, Culbertson Hall, Room 308, MSU, Bozeman, MT 59717. Registration will also be accepted at the door, if space is available.

IMPROVING MENTAL HEALTH CARE SERVICES TO MONTANA'S ELDERLY: NEW STRATEGIES AND SOLUTIONS TO ENDURING PROBLEMS

Friday, November 18, 1988
Colonial Inn, Helena

AGENDA

8:00 - 8:30 a.m.	Registration
8:30 - 8:45 a.m.	Welcome and Introductions *Louise Salo, Member, Governor's Advisor Council on Aging, Helena; and,* *John G. Nesbo, Executive Director, South Central Community Mental Health Center, Billings*
8:45 - 9:15 a.m.	Montana's Mental Health System *Montana's Mental Health Center's Directors*
9:15 - 9:45 a.m.	Videotape: "The Mental Health Problems of the Older Adult"
10:00 - 10:30 a.m.	Mental Health Services for Older Adult Data Compilation: An In-Process Review of Outpatient Diagnosis and Demographic Survey Data for Montana's Community Mental Health Service Regions *Gary A. Refsland, Director, Montana Center of Gerontology, Bozeman; and,* *Del Straub, Research Associate, Bozeman*
10:30 - 11:00 a.m.	Screening the Mentally Ill in Nursing Homes as required by the Nursing Home Reform Act (OBRA '87) *Mary Dalton, Program Officer, Economic Assistance Division, Dept. of Social and Rehabilitation Services, Helena; and,* *Dan Anderson, Chief, Mental Health Bureau, Dept. of Institutions, Helena*
11:00 - 11:30 a.m.	Discussion and Questions for the Morning Presenters
11:30 - 1:00 p.m.	Buffet Lunch with the Governor Elect
1:00 - 2:00 p.m.	Preliminary Legislative Issues and Concerns of Montana's Mental Health Care System *John G. Nesbo and Steve Waldron, Executive Director, Montana Council of Mental Health Centers, Moderators*
2:00 - 4:00 p.m.	Participants will work in Small Discussion and Exchange Groups on the following questions: 1. What ideas do you have for creatively delivering mental health services to older adults? -- *Sharon Harris, Psychiatric Nurse, South Central Community MHC, Billings* 2. What ideas do you have that would improve interagency cooperation in providing mental health services to the older adult? -- *Jim Mount, Director, Drug Treatment Program, Eastern Montana Community MHC, Miles City* 3. What ideas do you have for political and legal change in Montana legislative and public policy? -- *Sue Bennett, Clinical Social Worker, Mental Health Services, Inc., Helena* 4. What ideas do you have for developing collaborative relationships between the Community Mental Health Centers and other service providers? -- *David Washburn, Psychiatric Social Worker, Western Montana Community MHC, Missoula* 5. What ideas do you have for increasing funding to the Community Mental Health Centers? -- *Linda Hatch, Personnel Director, Golden Triangle Community MHC, Great Falls*
4:00 - 4:30 p.m.	Group Summary Reports
4:30 - 4:50 p.m.	Reaction to Summary Reports by Speakers
4:50 - 5:00 p.m.	Closing Remarks *Carl Erickson, Member, Governor's Advisory Council on Aging; and* *Gary A. Refsland*

CONFERENCE REGISTRATION FORM

IMPROVING MENTAL HEALTH CARE SERVICES TO MONTANA'S ELDERLY: NEW STRATEGIES AND SOLUTIONS TO ENDURING PROBLEMS

8:00 - 5:00 p.m.
Friday, November 18
Colonial Inn, Helena

PLEASE RETURN THIS PRE-REGISTRATION FORM BEFORE NOVEMBER 11, 1988 to:

Montana Area Health Education Center
Culbertson Hall, Room 308
Montana State University
Bozeman, MT 59717
Telephone: 994-6001

NAME

POSITION

ORGANIZATION

ADDRESS

CITY **STATE** **ZIP**

PHONE

SEMINAR PARTICIPANTS

"Improving Mental Health Care Services to Montana's Elderly: New Strategies and Solutions to Enduring Problems"

NOVEMBER 9, 1988
MENTAL HEALTH CONFERENCE

Participants: 54

Position	
Administrator	12
Director	16
Supervisor	1
Social Worker	9
Volunteer Coordinator	1
Board/Council	5
Nurse	4
Educator	1
Program Manager	1
None	4

Organization	
Community Mental Health Center	9
MT Center for Gerontology	2
Area Agency on Aging	4
Montana State Hospital	1
Dept. of Family Services	9
Rocky Mountain Development Council	1
Parkview Acres Convalescent Home	3
Mental Health Services, Inc.	2
Montana Center for the Aged	1
County Administration	4
VA Medical Center	1
Montana Governor's Office	2
Montana Mental Health Council	2
Cooney Convalescent Home	1
Montana State University	1
Indian Health Service	1
Aging Services Bureau	1
Private Gerontology Practice	1
Dept. of Health	2
Heritage Acres Nursing Home	1
Montana Deaconess	4
Senior Companion Program	1

Appendix L: Total Seminar Participants by Position Held

TOTAL SEMINAR PARTICIPANTS BY POSITION

POSITION	NUMBER
Activity Aide	2
Activity Coordinator	4
Activity Director	8
Administrative Assistant	1
Administrative Officer	1
Administrative/Office Director	2
Administrator	1
Adult Care Supervisor	1
Adult Day Coordinator	1
Adult Protection Unit Social Worker	3
Adult Services Supervisor	1
Aging Services Specialist	1
Aide	3
Assistant Administrator	1
Assistant Director	2
Assistant Professor	2
Assistant Program Director	2
Associate Professor	1
CD/MH Program Adm.	1
CHR	3
Case Management	3
Case Management Nurse	1
Case Management Social Worker	1
Case Manager	4
Chairperson	2
Clinical Coordinator/Director	2
Clinical Counselor	2
Clinical Director	3
Clinical Prac. Sup.	1
Clinical Psychologist	4
Clinical Social Worker	15
Community Care Social Worker	1
Coordinator	1
Coordinator of Counseling Education	1
Counselor	62
Dental Assistant	1
Director	21
Director, Clinical Support Services	1
Director, Day Treatment	1
Director, Nursing	7
Director, Psychosocial Services	2
Director, Rehabilitation	1
Director, Social Services	5
District Supervisor	1
E.I./E.T.	2
Employee Assistance Counselor	1
Family Service Spec.	1
Fund Raiser	1
Generalist	1
Geriatric Clinician	1
Group Home Manager	1

TOTAL SEMINAR PARTICIPANTS BY POSITION

POSITION	NUMBER
Head Nurse	3
Health Adm.	1
Health Care Surveyor	2
Health Educator	1
Home Attendant	6
Home Health Attendant	3
Home Services Director	1
House Manager	1
Human Services Aide	5
Instructor	1
Intensive Care Manager	1
Job Club Coordinator	2
LPC	2
Long Term Care Specialist	2
MSC	1
Medical Director	2
Medical Social Worker	9
Mental Health Technician	1
Music Therapist	1
None	90
Nurse	130
Nurse Aide	4
Occupational Therapist	1
Office Director	1
Optometry	1
Pastor	3
Physician	3
Professor	2
Program Manager	1
Psychiatric Aide	9
Psychiatric Assistant	4
Psychiatric Clinical Specialist	1
Psychiatric Nurse	1
Psychiatric Social Worker	1
Psychologist	27
Psychotherapist	5
Public Health Nurse	1
Public Health Program Assistant	2
Recreation Director	1
Recreational Therapy Aide	5
Regional Clinical Director	1
Rehabilitation Aide	2
Rehabilitation Therapist	1
SP	1
Secretary Chr.	1
Senior Advocate	1
Senior Companion	6
Social Services Designee	7
Social Services Designee/Director	9
Social Work Aide	1
Social Work Consultant	2

TOTAL SEMINAR PARTICIPANTS BY POSITION

POSITION	NUMBER
Social Worker	219
Social Worker Supervisor	2
Staff Development	1
Staffing Specialist	1
Student	12
Supervisor	3
Surveyor	1
Therapeutic Rec.	1
Therapist	16
Unit Supervisor	1
Volunteer Coordinator	2
*** Total ***	821